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IN THE CIRCUIT COURT OF WASHINGTON COUNTY, MISSISSIPPI

JEANETTE WILKES, DAUGHTER OF
ANDERSON SMITH, DECEASED,
INDIVIDUALLY AND ON BEHALF OF ALL
WRONGFUL DEATH BENEFICIARIES
AND THE ESTATE OF ANDERSON
SMITH, DECEASED

V. PLAINTIFFS

CIVIL ACTION NO. 91-123-55-(B)(W)

THE AMERICAN TOBACCO COMPANY AND
THE NEW DEAL TOBACCO AND
CANDY COMPANY, INC.

DEFENDANTS

DEPOSITION OF GRAY HILSMAN, M.D.

Taken at the instance of the Defendants on Thursday, February 4, 1993, at the offices of Alston, Rutherford, Tardy & Van Slyke, 121 North State Street, Jackson, Mississippi, beginning at 1:30 p.m.

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GRAY HILSMAN, M.D.,

having been first duly sworn by the court reporter, was examined and testified on his oath as follows, to-wit:

MR. SHEFFLER: I'd like to ask on the record, Mr. Scruggs, why are you here today?

MR. SCRUGGS: I'm counsel of record.

MR. SHEFFLER: Since when?

MR. SCRUGGS: Long time.

(Off the record.)

EXAMINATION BY MR. BARRETT:

Q. Would you state your name for the court, please?

A. Gray Hilsman.

Q. And Dr. Hilsman, the parties have an agreement that they will produce certain documents at these depositions, and I want to go over these categories and ask you about them.

A. Okay.

Q. The first set of documents were all documents and materials given to you by the defendants or their attorneys concerning Anderson Smith or the case styled "Wilkes versus the American Tobacco Company". Do you have those documents or do you know about those documents? Do you have them here today?

MR. BAILEY: They were delivered to you at noon.

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A. Those are the -- that's -- everything that I have was placed in that large box with the exception of what appear to be these three.

MR. BAILEY: Those three documents that I gave you earlier.

A. That I had with me in another location. That's the entirety.

MR. BARRETT: Let's go off the record.

(Off the record.)

MR. SHEFFLER: Mr. Barrett, I will represent on the record that the documents referred to as the medical records that Dr. Hilsman has reviewed are the same medical records that we have gathered pursuant to the authorizations by Anderson Smith and which we have produced copies of to you.

MR. BARRETT: Thank you.

Q. (By Mr. Barrett) You also said you had three other documents here today, one of which appears to be the interrogatory response that we made for Dr. Gilbert Macvaugh.

A. That's correct.

Q. Was that furnished to you by the tobacco company?

MR. SHEFFLER: It was furnished to him by me.

A. Correct.

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Q. (By Mr. Barrett) I notice that it has some underlining.

A. I did that.

Q. And it also has some writing in the margin, not much but a little.

A. That's mine.

MR. BARRETT: Let that be marked as Exhibit 1 to the testimony.

(Exhibit 1 marked for identification.)

Q. You also have a three-page document entitled "Gray Hilsman" which appears to be the same document that I have that was given to me as a response to an expert witness interrogatory stating what you're expected to testify about. Is that, in fact, what this is?

A. Correct.

Q. Did you prepare this or did somebody else prepare this?

A. My office did not prepare the document. The verbal material that's within that document was provided by me, and the attorneys prepared the written format of that which I reviewed and signed.

Q. Where did you sign it?

A. I'm sorry. Well, I -- I apologize. I thought --

MR. BAILEY: Signed off on.

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MR. BARRETT: Would you swear in Mr. Bailey so he can assist with the testimony here.

A. I suppose what I recall is when they sent me this document I signed that I thought it was actually on the document. It's my opinion, contains my opinion.

MR. BARRETT: Let this be marked as Exhibit 2.

(Exhibit 2 marked for identification.)

Q. (By Mr. Barrett) And the third document that was produced today is a copy of an article entitled "Philosophy in a learned profession: Observation and Thoughts". Could you tell us what that is, please?

MR. SHEFFLER: Objection. The document speaks for itself. It is what you said it was.

Q. (By Mr. Barrett) What's it about?

A. About rational health care choices, the gist of which is that longevity per se of life may not be the philosophical issue that we should be looking at but quality issues as compared to pure longevity issues. It's fairly specific, at least in -- it says what it says. It's not terribly erudite or deep philosophically.

Q. And where did this article, how did it come to be in your possession?

A. It was given to me by the attorneys that represent the tobacco industry.

Q. And when did they give it to you?

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A. Monday, I believe.

Q. That's Monday of this week?

A. Correct.

Q. What did they tell you when -- which attorney gave it to you?

A. The attorney to my left or direct left.

Q. That's Bruce Sheffler?

A. Correct.

MR. SHEFFLER: Who represents the American Tobacco Company just so the record is clear, not the tobacco industry, in case there's any doubt.

A. The -- my understanding was he gave it to me just for my information, actually. It certainly proposes some notions that are being held more strongly now with spiraling health care, and I'm sure that -- you know, its appeal to me actually had nothing to do with this case, but other issues that were brought up, it certainly has some mention about the health care industry and smoking, but honestly, the part of that that I actually read to -- and I will show you where that stopped -- was to this point right here. From this point further other than --

Q. (By Mr. Barrett) Let's mark -- is this a line right there?

A. Correct.

Q. And so you --

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A. That is where it stopped.

Q. You put an "X" on page 519 is where you stopped --

A. Correct.

Q. -- reading.

A. You read the first two pages of this, and you get the drift of it, and if you've read one of these, you've pretty much read them all.

Q. How, if at all, does it relate to this case?

MR. SHEFFLER: I think the doctor just answered that in his last question, Don.

A. I can only tell you how the first whatever this would be, two and a half pages relate, and that would be largely based on the fact, if any relevance whatsoever, that there is an issue related to mortality and economy and an issue related to quality of life, but I don't know how, you know, that would specifically relate to this case.

Q. (By Mr. Barrett) Okay.

A. It related more to mow based on some of the decisions that I deal with in part of what I do as far as teaching, and that being ethics.

MR. BARRETT: Let that be marked as Exhibit 3, please.

(Exhibit 3 marked for identification.)

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Q. The second category of documents to be produced today were all documents and materials given to the defendants or to the attorneys by you concerning Anderson Smith, Jr., on this case.

A. The only thing I know that I gave them was my veto.

Q. Okay.

MR. SHEFFLER: Attached to his report given to you some time ago.

Q. (By Mr. Barrett) Right.

A. That's the only thing I furnished them.

Q. All documents -- number 3 is, "All documents and materials reviewed by you concerning Anderson Smith, Jr., or this case," and I believe you've already said that those documents are in this brown box here which consists of the medical records that Mr. Sheffler has just spoken about.

A. That's correct.

Q. Number 4 are, "All documents and materials in your possession concerning Anderson Smith, Jr., or this case."

A. I have nothing else.

Q. Number 5, "All documents and materials relied on by you in reaching opinions in this case."

A. Well, now, the obvious impossibility of that is

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that you -- how do you produce every journal or article you ever read or every textbook that you ever gleaned information. I have no specific document to kind of throw at you or level at you. The material from which I will speak would be available to anyone through any well-recognized psychiatric text.

Q. Number 6 is "All written reports including all drafts and notes of the opinions set forth in plaintiffs' Exhibit 2."

A. That's all I have.

Q. Did you ever make any other written reports?

A. No.

Q. Never made any notes?

A. Not any notes. Well, specifically, the -- there may well have been some notes made. The problem with that is that that box that you have at your feet actually re -- those documents or a copy of those documents I had at my disposal whenever this started, a year ago, whenever it was, and in a -- whether it be change of secretaries or change of storage sites, et cetera, no one could find those documents. It was assumed they were lost when the storage thing -- when we switched storage sites and just simply lost, because a several day search, and as you can see, it's a large, massive amount of documents came up missing, and in fact, those documents did not arrive in my

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possession until last Thursday or Friday, so the original review of those records, which admittedly took place well over a year ago, I have no idea where they may be. They're certainly not in my possession, and I have no specific notes to -- to those documents, and I honestly do not remember having any, other than maybe what would have been penciled in the margins or something like that as I would have reviewed them.

Q. "All written communications between you and the defendants counsel concerning Anderson Smith, Jr., or this case," is the next category.

A. I have none.

Q. Were there ever any?

A. No, they were not part of what was lost. There never were any.

Q. Number 8 is "All documents and materials in your possession concerning the Tobacco Industry Research Committee, the Council for Tobacco Research, the Tobacco Institute or the American Tobacco Company."

A. I have none.

Q. And never had any?

A. Huh-huh.

Q. Number 9, "All documents and materials in your possession concerning cigarette advertising."

A. Huh-huh.

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Q. Never had any?

A. Never had any.

Q. Number 10, "All documents and materials in your possession concerning public relations and cigarette companies."

A. Huh-huh, no.

Q. Never have had any. As to either of those last two categories, have you ever studied either one of those topics prior to being retained by the American Tobacco Company?

MR. SHEFFLER: Objection on two grounds: Number one, it's a compound question, but number two, I think the question is a bit ambiguous, Don. What exactly do you mean, has he ever studied what? Can you tell us specifically?

Q. (By Mr. Barrett) Did you understand the question, Doctor?

A. Do you mean have I ever studied the precise mechanism that the tobacco company used to direct its advertising, no, but in a finite sense, I have not had any exposure dealing with the tobacco company's specifics in an advertising campaign whatsoever.

Q. Okay. Number 11 is "All documents and materials in your possession concerning the risks of smoking cigarettes."

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A. Don't have any.

Q. 12, "Copies of all invoices, statements or bills created or submitted by you for services rendered or to be rendered in this case."

A. Strange enough, I don't have that. I can tell you and I think because of the card was attached to this, I had -- again, to the best of my recollection, I had spent probably three hours directly with the attorneys in this matter, and probably spent, I would guess, in excess of that amount of time in reviewing these records, and I don't think they have record of this, because we kind of jokingly said something about it, and that was submitted approximately a year ago for $600.

Q. Okay.

A. And I have in my memory that they paid me. They don't have that memory, but I have memory that they paid me. But the --

Q. How much did you charge them an hour?

A. I charged them -- it depends upon how you look at it. I charge $200 an hour for eye-to-eye legal contact work. On many of these, I -- because I sometimes go slower and go back over, I don't charge -- sometimes I don't charge anything for review of records if it's going to take less than a couple of hours. If it's going to take kind of an inordinate length of time, I charge the

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same rate that I charge in the office which is $95, but it's probably easier to assume like today, eye-to-eye, in-house contact is $200 an hour, and for review of information that I would consider lengthy would be at $95 an hour.

Q. And to the best of your knowledge, are you saying that you --

A. The only money that I have generated out of this has been $600.

Q. And how much -- do you have unbilled hours?

A. I have what would be probably six unbilled hours and probably three -- I'd have to relook it up, three to four which would be the seven or so, however many that would be, I'd have to look it up precisely, would be at $200 an hour, and there's probably about close to four hours it would be at 95, so it's probably an outstanding bill of whatever that would be, $1,100, something like that.

Q. These documents that you produced today which are the ones that replaced your other document, are a foot or so thick. Apparently, you haven't spent a lot of time reviewing these on a page-by-page basis; is that a fair statement?

MR. SHEFFLER: Objection. Doctor, before you answer, let me object to -- I don't know exactly what you

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mean by a whole lot of time or what. If you wanted to ask him how much time he spent reviewing the documents, why don't you ask him that question rather than asking him a question that's ambiguous and objectionable. Why don't you ask him how much time he spent reviewing the documents.

Q. (By Mr. Barrett) Go ahead, Doctor, answer the first question.

A. If you'll take those records out, what you'll find is that like so many things in life a lot of coconut, not much meat. The majority of those documents would involve materials that would have, at the best, limited esoteric value. The --

Q. What do you mean by that, "esoteric value"?

A. Oh, financial record that so and so was re-seen or another -- a note from the VA Hospital or a statement sent from the mother to the, you know, the VA. The real medical documents in that record probably, oh, I would guess you could boil them down to no more than 40 percent of the mass of that chart, and that would include, you know, the progress notes and any specific reports, inpatient, outpatient, psychological, social work histories, et cetera, and I probably spent, oh, directly on those records -- and obviously I re-reviewed them when they came back into my possession, I would suspect no more

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than four or five hours on that particular part of it.

Q. Okay. Document request number 13 is your most recent curriculum vitae.

Q. How do you spell V-I-T-A-E or V-I-T-A?

A. V-I-T-A-E.

MR. SHEFFLER: Did we misspell it?

MR. BARRETT: No, you spelled it two different ways, but so did I, so that's all right.

Q. (By Mr. Barrett) Is the CV that you've given us, is that your most recent?

A. Yes, to the best of my knowledge, it is.

MR. UPSHAW: Look at it.

(Off the record.)

MR. BARRETT: Let the curriculum vitae of Dr. Hilsman be marked as Deposition Exhibit 4.

(Exhibit 4 marked for identification.)

Q. (By Mr. Barrett) Doctor, according to our agreement, you were to produce the documents and materials listed in your CV. There are two publications. Do you have those?

A. I don't. In fact, I don't know how to procure them.

Q. Okay. The "Effects Of Social Stress On Operant Drinking Of Alcoholics And Social Drinkers," what was that about, without repeating the title to me, what was the

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gist of that?

A. As simple as it sounds is that stress would increase the demand for alcohol in someone who was defined as an alcoholic.

(Off the record.)

Q. And "Thanatology", is that how you pronounce that?

A. Uh-huh.

Q. "In Medical Education," what's that about?

A. Study of death.

Q. In medical education?

A. Teaching the study of death to medical students and residents.

Q. I see. Are there any other publications that you've authored that are not --

A. No.

Q. Dr. Hilsman, for our mutual convenience, I have made a copy of response entitled "Dr. Gray Hilsman" that was provided to me, and I've made a copy of it for you so we can talk about it together.

A. Okay.

Q. I'll ask you to look at it, and I'll tell you that I have marked some things in yellow that I'm going to talk about with you later on, and I have marked them 1 through 14 in the right-hand column, and those are my

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figures, not yours, but other than the yellow highlight and the numbers on the right-hand margin, is that the same document as Deposition Exhibit 2 which is the report of your testimony?

MR. SHEFFLER: Excuse me, but do you want him to compare that to see if those documents are exactly the same? Is that what you're saying?

MR. BARRETT: Well, yeah.

MR. SHEFFLER: We can stipulate it is the report that we gave you was the same as Exhibit 2.

MR. BARRETT: That's fine. We'll move on.

Q. (By Mr. Barrett) I want to ask you just a few things. When was this document prepared?

MR. SHEFFLER: To the best of your recollection.

A. In '91, but I cannot tell you when.

Q. (By Mr. Barrett) When were you hired?

A. I cannot tell you that.

Q. You have no records?

A. Huh-huh, that was destroyed, and I know -- I'm sure -- it's easy enough, obviously, to obtain, but I do not know the precise date of that.

Q. How would it be easy to obtain?

A. I assume the attorneys would know when they hired me. They would probably have a written record of

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it. I don't.

MR. SHEFFLER: Don't assume anything, Doctor, especially with respect to our records.

A. Oh, I'm sorry. I know I don't have it.

Q. (By Mr. Barrett) Now, you testified earlier that these -- that these are your words, is that --

MR. SHEFFLER: Objection. That was a mischaracterization of the testimony he gave. He told you specifically that he gave us that information. We prepared that document and gave it to him to read to sign off on. Now, you are mischaracterizing his testimony. He never said that those were his words, and you know from our past dealings that they are not his words, they are our words, and we represented that when we were answering interrogatories to you when we gave you that document. That's a mischaracterization, Mr. Barrett, and I object to the question.

Q. (By Mr. Barrett) Are these your words or the tobacco company's words?

MR. SHEFFLER: Objection.

A. They are both.

Q. (By Mr. Barrett) Which are your words?

MR. SHEFFLER: Objection.

Q. (By Mr. Barrett) Can you go through there and indicate which are yours?

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A. Well, no, and to be honest with you, one thing about me, the precise wording of this really, to me, is not nearly important as the fact that this document holds the views that I have and that they were -- rather that that document, actually, was prepared and viewed by me and accepted by me as my opinions, and certainly within here are my words, are my thoughts which would probably be far more important than my words.

Q. Okay. When is the last time prior to this deposition that you had a meeting with the attorneys?

A. It would have been, to the best of my recollection, months ago or a year.

Q. You didn't meet with them today or yesterday to talk about this?

A. I'm sorry, I'm sorry, I apologize. I thought you meant in months past. I met with them on Friday afternoon, and I met with them -- I'm sorry, on Thursday afternoon, and I met with them on Monday afternoon of -- Thursday of last week and Monday of this week.

Q. How long did you meet with them on Thursday?

A. From 1:30 to approximately 4:45 and on Monday from approximately 2:30 to 4:30, somewhere just after 4:30.

Q. On Thursday afternoon, who was there, what attorneys were there?

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A. To my --

Q. The two attorneys from New York?

MR. SHEFFLER: Let the record reflect that Dr. Hilsman indicated that Mr. Sheffler and Mr. Reilly, Jack Reilly were present at the meeting.

MR. BARRETT: Who are both from New York.

MR. SHEFFLER: There's a lot of attorneys from New York, Don.

Q. (By Mr. Barrett) On Monday, who did you meet with, Dr. Hilsman?

A. Same two people.

Q. What did y'all talk about on Thursday?

A. We talked about the medical records and, primarily, the data that were included in those medical records and this document.

Q. Well, tell me specifically about those -- what do you remember about those records that you discussed specifically?

MR. SHEFFLER: Objection to the question. If you're asking what did he remember of the discussion of the specific medical records, I'm going to ask you to narrow that, because as he just indicated or you indicated, it's about a foot thick.

Q. (By Mr. Barrett) Did Mr. Sheffler or Mr. Reilly point out any particular of these documents to you?

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A. No.

Q. Did you point out any to them? Did you talk about any specific documents?

A. Oh, yeah, talked about, you know, primarily the man's psychiatric history, and, obviously, his psychiatric admissions and his medical admissions from the '83 admission and his medical admission that was, I think, the '85 and then just right into '86 admission.

Q. What did you talk about on the '85 and '86, this last admission?

MR. SHEFFLER: Objection, objection. To the best of your recollection. You're talking about both meetings, any meetings?

MR. BARRETT: Talking about last Thursday with Mr. Sheffler and Mr. Reilly.

MR. SHEFFLER: If you can recall, fine.

MR. BARRETT: Of course, any answer would have that.

A. The specifics of what was said and what questions were asked, I honestly can't tell you. I can tell you that what I did with that meeting was simply try to verbally go over material and ascertain honestly if there was any other material that was available, was there any other material that might be beneficial to me in reference to the ultimate court case and certainly to the

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deposition at hand, and that the -- really, it would be impossible for me to tell you what happened on Monday as opposed to what happened on Thursday, because basically it was simply kind of a rehashing of the same material.

Q. (By Mr. Barrett) What was significant to you about the medical records from his last admission at the VA Hospital?

MR. SHEFFLER: Objection, significant to him in what regard?

Q. (By Mr. Barrett) In connection with any opinions you're going to give in this case.

MR. SHEFFLER: Objection, unless you want to specifically ask him about an opinion and ask him about the records for the basis for that opinion, I object to the quesiton. The fact the man died is important to his opinion that this case is about a wrongful death action. Totally objectionable question.

A. Medical records are kind of like novels, and you know, everybody has a last chapter, but until you kind of review that last chapter, you've not finished the book, and you know, there's -- there is material that is contained in that final medical record that is, I think, germane to this case. Certainly the two major ones that I can think of would be the fact that it documents a 1941 date as his instigation to smoking cigarettes, which I

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think is important because it precedes his development of schizophrenia, and I think it's also important that he -- that the discussion of his mental illness and its symptoms, at his what would be end stage of his life is, you know, interesting to me, the way it was discussed, and I guess finding --

Q. (By Mr. Barrett) Did that affect your opinion in any way?

MR. SHEFFLER: Let him finish his answer before you ask another question.

A. The entirety of those medical records, it would be like saying did Leviticus affect your opinion of the Bible specifically. I mean, taken as a whole, the Bible affects your opinion of the work. Taken as a whole, his medical records affect, to me, the life -- medically the life of this man that we're discussing, but I couldn't tell you that, you know, one affected me and one didn't. I don't know myself that well. I do think there's some real important points in it.

Q. (By Mr. Barrett) What are some of those important points in it?

A. Two that I've certainly just named, and I believe -- and I would have to look at it again, but I believe that's the medical record that does --

MR. SHEFFLER: Doctor, let me caution you right

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now, if you want to see any of the medical records, you have the right to see that at any time during the deposition. It is not a mental test and it's not a test of your recall even though Mr. Barrett may think it is. If you'd like to see the records to answer any of the questions Mr. Barrett asked you, certainly have the right to ask for them.

A. The last thing I was just going to say is it gives you certainly kind of a thumbnail sketch of what he was like, at least as it manifested itself to the people who wrote notes in that chart as far as emotional level of function.

Q. (By Mr. Barrett) What was he like at that time according to the way you read the chart?

A. Well, probably it was more what he wasn't like.

Q. Explain that.

A. Well, why don't you get the chart, and we can hash over that, and I'll show you.

Q. Is there anything particular, I might be able to find it for you if you can tell me what you're looking --

A. The progress notes from the last admission.

Q. This is the entire record from the last admission. Keep them in order if you would, please, sir.

A. All right. Of course, as you're aware, in this admission, it documents the 1941 date. When we get to his

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-- on the history -- and I'm reading from the last admission, the intake history page that is listed as part 3, systems review, 16 is the neuropsychiatric system review, and I can provide for you at a later time what that entails.

In other words, pulmonary review of system entails a thorough evaluation of whether it had shortness of breath, dyspnea, all those type things. A neuropsychiatric review as you would expect is also fairly encompassing, and the only thing, as you well know, I'm sure, is it says here, "Is a very poor his attorney, is alert and oriented." There is absolutely no mention of any psychotic symptoms whatsoever in that review, which I think, you know, pretty well speak for themselves.

Q. No, no, excuse me, sir. What does it say to you?

A. It says to me that, assuming that he obtained good medical care, which I'm going to work with the assumption that he did, that in the review of systems that they listed no evidence of any active psychosis which would be part of the material that they would generate, particularly when they knew this man had a history of mental illness.

Q. So you're saying it's your opinion, based on those records, that he did not have an active psychosis at

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that time?

A. I'm saying that based on what they said you would be led to believe he may very well didn't.

Q. Is that your opinion?

A. I don't know. It's my opinion that they did not see active evidence of psychotic behavior or thinking, and that is my opinion. When you go to the -- the part on the physical examination, there is no mention, either, of any psychiatric disease whatsoever. When you do, though, jump into the medical records, the progress notes -- let me back up here. Give me just a second.

Yeah, I know, and I've got -- I'm going to say something from that as well.

Q. What did Mr. Sheffler just say to you?

A. That these are the orders. It's not the progress notes, but I was going to say something to them, and rather than getting them out of whack for you to have to reinstate, it would be easier for me to do that here.

MR. SHEFFLER: What was the last question that was asked by Mr. Barrett?

(Record read.)

MR. UPSHAW: Doesn't all this relate back to his answer when he said it's more what the records don't say than they do say and you --

MR. SHEFFLER: I don't know what question we

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have on the record right now. Mr. Barrett, why don't you rephrase the question so we all know what we're answering.

MR. BARRETT: Well, I'm trying to get Dr. Hilsman to tell me what is it in these medical records that affects your opinion concerning his mental state and any of the opinions you're going to give in this case of this -- of his last hospitalization, and I would really, although this is not a memory quiz, and you're certainly entitled to look at those if you want to, I'd like to know, just off the top of your head, what you remember, and then go into some more if you'd like. Might be quicker for all of us.

MR. SHEFFLER: Let me just make an objection, for the record, to the extent that you're asking him to go through the record and find anything that affects his opinion, I would object because I don't know what the word "affects" means. If you mean anything that's relative to his opinion, anything upon which he may base his opinion, then I would certainly say the question is objectionable because Dr. Hilsman may very well be called to ask for opinions on a lot of things in these records.

If you have a specific opinion in his report that you wish to seek a basis for from the record that he's looking at right now, I have no objection to that

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question,. So far, you haven't identified that. Do you understand what he's asking you to do?

A. Uh-huh, I think.

Q. (By Mr. Barrett) Everybody does but Mr. Sheffler.

MR. BAILEY: I don't.

MR. SHEFFLER: I think the record is going to be completely muddled and unclear, and I object to the question, but if the doctor can answer it, so be it.

A. From the top of my head, what I was searching to give you some verification for is what isn't here. What isn't here is that he's not portrayed as actively hallucinating, he's not portrayed as paranoic, belligerent, agitated, hostile, aggressive, out of his mind, wandering the halls blindly. He's portrayed as somebody who is, you know, not a young man who is only as far as "negatives" that I can think of, poor historian, and there are a couple of statements, and I just wanted to give them to you specifically, first one that I'm aware of occurs in this 1/4/86 note where he's described as having loosening of association. Unfortunately, that is not specifically stated as to what that means.

Along about the 7th of January of '86, the records are reviewed, obviously, and the diagnosis from the old records of paranoid schizophrenia are placed. The

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intriguing thing is, to me at least, that if I didn't know the person was a paranoid schizophrenic and these people had thought he was demented because that's what they say, but then I find out that they're not psychiatrists, they're not supposed to know everything, but then I find on the 7th that what we're dealing here with here is a person who has paranoid schizophrenia.

Number one, knowing that, subjectively I might start changing things to kind of reflect paranoid schizophrenia, and number one, it doesn't happen. There's no reflection. I mean, you get one more statement of this loosening of association repeated on the 9th, and for the most part, that's it. The other thing that's to me real interesting is -- and that's why I was going to give you the medical records -- I mean the orders, they don't do anything. They don't put him on any kind of medicine for his paranoid schizophrenia. He's not on any medicine for his paranoid schizophrenia, and what that tells me is that they didn't see anything that they thought needed to be treated because they didn't treat it. And I think that does state fairly strongly, or you can make some implications as to what degree of remission this man was in at his -- really at what we'd say would be his medical worst, and considering that medically there could be all kinds of possibilities going on here with his poor

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historian data could easily be accounted for by a delirium imposed on him by virtue of his illness, God knows, it's so many things it could be, and as I say, it's not so much what's there, it's what's not there. It's not recounting of the picture that I think active paranoid schizophrenia certainly would have.

Q. What are the signs and symptoms of paranoid schizophrenia?

A. Predominantly, the delusions, the paranoid delusions, whether they be accusatory, referential or grandiose, based within the context, obviously, of the diagnosis of schizophrenia, but I'm sure you'll get into that in these questions.

Q. Let's go over your -- get into the meat of your opinions here. Look at number 1 where you say that it's your opinion that "...people commonly choose to engage in pleasurable activities with full knowledge of the perceived risk attendant to such activities." What did you mean by that?

A. That people choose activities that bring them pleasure and that they are aware that some things that may bring us pleasure as human beings have risks attached to them.

Q. Can you give us some examples of what you're thinking about there?

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A. Well, you could -- I mean, certainly it would be totally apropos to this case, smoking, but certainly people who participate in any hobby that would have any risk attached with it, commonly I guess we think of the more kind of dramatic ones, sky diving, but you could go all the way to mountain climbing, skiing, scuba diving, anyone in this room would be able to imagine a myriad of hobbies that would have a risk attached to them. One might go so far as to say using cellular telephone, I suppose, today, but it's -- I think the gist of what I meant is that human beings are given choices, and some of those choices involve activities that may bring them pleasure or happiness or fun or whatever word you want to attach to that and that some of those activities may have a risk attached, and that, really, most pleasurable activities do have a risk attached to them, like it or not, and that I think that human beings have the ability to, in a gross sense, perceive those risks.

They may not know the exact number of people that break their leg skiing or fall off a mountain, but they have a pretty decent working idea that it has a perceived risk.

Q. You say humans have that, but you don't mean all humans, do you?

A. I do not mean all humans, that's true, people in

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comas, people that would be, I suppose, in near comas probably certainly wouldn't have ability to perceive a risk.

Q. Well, isn't it also true that there are people who engage in pleasurable activities without full knowledge of the perceived risks?

MR. SHEFFLER: Objection, unless you mean every pleasurable activity.

MR. BARRETT: I just turned his statement around and asked the converse of it, Doctor.

A. Say it again.

Q. (By Mr. Barrett) Is it not true that other people commonly choose to engage in pleasurable activities without full knowledge of the perceived risks attendant to such activities? It's just the other side of your statement.

A. Uh-huh. Well, I suppose that surely somebody had done that. I mean, it's -- you've got two words in there that are kind of, as you know, catch words, and that's "everybody" and "full".

Q. That's right, and that are your words.

MR. SHEFFLER: "Everybody" doesn't appear in there.

A. Right, and I think the colloquial concept of full knowledge, by that he would have an adequate working

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knowledge to make an opinion.

Q. (By Mr. Barrett) Don't children sometimes do pleasurable but dangerous things without knowing better?

A. That's correct.

Q. That's why we have baby-sitters, isn't it?

A. That's correct.

Q. And you say people in comas, what about insane people?

A. That's too vague for me.

Q. Okay. What about some mentally deranged people? Do you agree that some mentally deranged people engage in pleasurable activities without full knowledge of the risks?

MR. SHEFFLER: Including those in comas?

Q. (By Mr. Barrett) Forget people in comas. People in comas, I assume, would be like people asleep.

MR. SHEFFLER: How about children, is that forgetting those, too?

Q. (By Mr. Barrett) Yeah, forgetting children, too.

A. I believe there are people who you will use the word insane that at certain part or points in their illness would not be able to perhaps perceive all the attendant risks of an activity. That's correct.

Q. Now, you said in your statement that they choose

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to engage in these activities with the full knowledge of the "perceived risks".

A. Uh-huh.

Q. Is the term "perceived risk" as you use it there any different from the word "risks"? Could you say risks and mean the same thing, or do you have a different shade of meaning?

A. I think "perceived" has to be the operative word, because I think various cultures perceive risks differently, and how our culture would define a risk as compared to another culture takes within far more than just the word "risk", and I like "perceived". I mean, it may be something that I like --

MR. SHEFFLER: You've answered the question.

A. I would be unhappy with the word simply "risk".

Q. (By Mr. Barrett) Does "perceived risks" mean that there may not be risks, in fact, but only risks that are -- only something that's thought to be a danger, is that what you mean?

A. It means that or at least to me that a person -- you and I may have a difference in opinion of the risk of, say, football. You may find that playing football has essentially no significant risk to you. I may perceive that it has a lot of risk to me, and in that sense, I think it has a certain subjecticity that I think is

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different from person to person and situation to situation.

Q. Thank you. But will you agree that football has an objective risk insofar as a certain number, a certain percentage of football players are going to get their next broken.

A. Uh-huh.

Q. A certain percentage of football players are going to get ligaments torn in their knees.

A. Uh-huh.

Q. So in another different sense, there are objective risks; are there not?

A. True. Which may be if same -- they may, in kind of a -- they may many times be the same, what was perceived would have been in the same grouping as those that were objective, surely.

Q. Look at number 2 there,"...millions of smokers choose to smoke with full knowledge of the perceived risk of smoking."

A. Uh-huh.

Q. What do you mean by that?

A. That approximately 30 million Americans smoke cigarettes knowing that the Surgeon General and essentially all branches of medicine have said that it poses or may pose risks to ones health.

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Q. Is that it?

A. Uh-huh.

Q. Do you have any specific documents that you would use to back up that expert opinion or have you been furnished with anything by the American Tobacco Company?

A. You mean as far as 30 million?

Q. Yes.

A. That figure is readily available. I could give you a textbook that had that.

Q. Which textbook?

A. I can furnish it. It's a synopsis of Harrison's textbook -- I mean of -- I can provide you that, be happy to.

Q. Have you ever read the Surgeon General's Reports?

A. In total, no, I have not.

Q. I doubt that the Surgeon General has for that matter. But are you familiar with the Surgeon General's Reports, do you know what they are?

A. I know what they are. I have not reviewed the Surgeon General's document, no.

Q. Do you understand that they are reliable and authoritative in the field of smoking and health issues?

A. Correct.

Q. Do you agree that there are other smokers who do

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not have the full knowledge of the risk of smoking?

A. I would agree with you that --

MR. SHEFFLER: Before you answer, objection. You said there are other smokers that do not do not have -- what does the "other" have reference to?

Q. (By Mr. Barrett) Go ahead and answer the question.

MR. SHEFFLER: No.

MR. BARRETT: All you can say is object to the form.

MR. SHEFFLER: I do object to the question because it's ambiguous, and I don't think you laid a proper predicate for the question. What does the "others" refer to?

Q. (By Mr. Barrett) Go ahead.

A. There's probably no one in this room that knows the specific risk or alleged increased risk of pancreatic cancer with cigarettes. I mean, everybody in this room is intelligent. You've reviewed all this data, and you don't know it probably. I only know it because I reviewed it. It's something I'll surely forget between now and March. The precise risk, percentage risk, chance risk, which as you well know, I'm sure, has changed as data has been accumulated and better studies have been formulated.

What we do know is that surely no individual, to

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my knowledge, probably including the Surgeon General, knows the precise risk to all organ damage that cigarettes may or may not cause, and in that sense, I would completely agree with you, that I don't think anybody does, except somebody who recently edited that paper or who has privy to 1993 data. I just don't think they know.

Q. What do you mean when you say full knowledge of the risk of smoking? What do you consider full knowledge?

A. Full knowledge to me means that cigarettes appear, certainly, to cause health risk to the body as a whole, including primarily the lungs and the cardiovascular system, as well as the oral pharynx. Certainly there are other studies that would indicate that that's more widespread and would affect the GI system, the bladder, the uterus, et cetera.

I think most people, if you were to poll today, that has had any ability, any form of communication, whether it be written, oral or visual, would be aware and could tell you that cigarettes are led to be harmful to the health, and that is what I mean by that they have full knowledge of the perceived risk of smoking, that smoking is "dangerous" to your health, may be dangerous to your health, may cause lung cancer, may cause cardiovascular disease.

Q. Or it may not. You say "may", does that also

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mean it may not?

A. There would be those who would argue, not so much I think that it does not or certainly probably does not contribute to these factors, but, you know, we -- these are early studies were probably faulty in that they were not as designed as perhaps they should be. A lot of different phenomena have occurred, some kind of a rural environment to a more city environment. Some of the data, some of the risk data may be negatively skewed to the tobacco industry, and that's not to say that certainly smoking cigarettes does not certainly appear with all the data that I've read to be associated with any number of diseases, but some of that precise numbering of this much more risk or these number of cases of this, that and the other did not take into account some of the other environmental hazards that these people were exposed to. And only most recently have there been, you know, risk studies that have been looked at trying to pull away some of those other environmental risks.

But I'm not here to tell you that I believe that cigarette smoking is healthy or that it does not have an attendant risk at all. I am clearly not here to tell you that. I'm simply here to tell you that I don't think anyone in this room or anybody that I've ever met could give you all of the various precise risks.

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Q. Would you agree that there are some children who smoke who do not have full knowledge of the dangers?

MR. SHEFFLER: Objection.

A. I have honestly not thought of that. I'd be happy to think about it, and I'll give you an answer at a time --

Q. (By Mr. Barrett) Think about it. Do it.

A. I don't know. When you say "some children", I'm sure surely there must be some case scenario where that is probably true. It would be hard to believe that they would not come in contact with some admonishment, but knowing all things are possible, I'm sure you're right.

Q. Is it your opinion that most children would have full knowledge?

MR. SHEFFLER: Objection. 51 percent?

MR. UPSHAW: Don, you haven't defined children. Is that an one year old?

Q. (By Mr. Barrett) Up to 18.

A. I think most -- if you're going to use children and primarily mean 12 to 18 years old, which would be the population that would probably smoke the most in that age group, yeah, I think they know the attendant risk.

Q. Okay. Do you think, then, that those 12 to 18 year old children should be able to choose for themselves whether they should smoke or not?

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MR. SHEFFLER: Objection. This is totally -- are we talking about the people who do smoke or the people who know the risks? What does "those children" refer to.

Q. (By Mr. Barrett) Go ahead, Doctor.

A. I think that the attempt that society to take care of its children is probably certainly well-known and a part of our limiting these people the ability to buy cigarettes until some specified age which, as you know, is completely different in one culture as compared to another, in different countries, and probably if there were not Federal government regulations, they would be different from state to state.

I think the idea is a good one in that we like to try to take care of our children. I think to legislate behavior is always dangerous. I think common sense puts us in a point where we know the impulse control of an 18 year old may be somewhat bern better than that of a 12 year old. You can take this thing into absurdity. You know, is a person a day before his birthday somehow to be protected, but the day after his birthday, all of a sudden, he has developed full knowledge of all attendant risk. Some of this is common sense.

Our society protects its children, and I think that's a great idea, and I'm supportful of that, even though I know intellectually that legislation for

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protection always has some risk of -- of attaching motive, and I think the motive there is to protect children from any potential known risk, and I think it's a good idea in that sense.

Q. Why would children need to be protected as opposed to adults?

MR. SHEFFLER: Let me object, and let me state for the record that I think we're getting pretty far down this road. I've let you go for a while, but as you know, Don, legally, under Mississippi law, until you're 18, you cannot smoke cigarettes. They cannot be sold to minors, so I don't know where you're going with these questions, I've given you latitude, but let's bring it to a close fairly soon.

Q. (By Mr. Barrett) Go ahead, Doctor.

A. What's the question?

MR. BARRETT: Read the question.

(Record read.)

MR. SHEFFLER: Object to the breadth of the question.

A. I think the assumption there certainly is that children, many times, don't know what is in their best interest.

Q. (By Mr. Barrett) What you're saying is, is it not, that although most children have what you call full

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knowledge of the dangers of cigarettes, even so, they lack the judgment to deal with that knowledge; is that what you're saying?

MR. SHEFFLER: Objection. It's not what he said.

Q. (By Mr. Barrett) Do you agree with that, what I just said?

MR. SHEFFLER: Objection.

A. I don't know if it's the judgment or the impulse control. I would -- and that's a thin line. I think it's, more than anything else there, high risk of peer pressure, their high risk of having a higher threshold of abandonment, that is an era where they do not believe or largely they do not believe that they can be harmed, probably protecting through that maturational window to where they can then kind of act more in the service of their ego is probably, at least in my opinion, the intent of those laws that protect children.

Q. (By Mr. Barrett) Do you agree that children, even if they have what you call full knowledge of cigarettes, do you agree that children generally lack the judgment to deal with that knowledge and make a responsible decision?

A. I don't think it's just that knowledge. I think it's -- they may lack the strength to -- to defer to

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intellectual material.

Q. So it's a lack of strength and a lack of judgment, too, is that what you're saying?

A. Can be.

MR. SHEFFLER: Objection.

Q. (By Mr. Barrett) Sir?

A. I would stand on what I said, that it was a lack of, at that particular point in time, perhaps a lack of appreciation of vulnerability.

Q. Is that any different than lack of judgment?

A. Oh, yeah.

Q. Do you think that children have -- do you think children ordinarily lack judgment that they will obtain later when they grow up?

MR. SHEFFLER: Objection. We're talking about children. I presume we're still talking about 12 to 18 years old, is that right, Mr. Barrett, or are we talking about one year olds. I object to the question.

Q. (By Mr. Barrett) Go ahead, Doctor?

A. If you'll repeat that.

MR. UPSHAW: I think we need to instruct him not to answer until he defines a child. I mean, we don't need to talk about one year old children. We need to define what the word "children" means or else --

Q. (By Mr. Barrett) We'll go at different ages.

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That might be productive.

MR. SHEFFLER: Before you begin your question, let me also state for the record that we did not produce Dr. Hilsman today as a pediatric psychiatrist or an expert in pediatric psychiatry. If you wish to continue this line of questions, I think you're going to have to establish that he is an expert in that area, and I think you're going to have to establish that you're calling him as an expert because we are not. I'm telling you for the last time, we're close to the edge here. If you're going to continue in this line of questioning on pediatric psychiatry, we're going to stop it.

Why don't we take a break, take a five minute break right now.

MR. BARRETT: I don't need a break.

MR. SHEFFLER: Well, I do. You figure out your questions, and when we come back, maybe we can direct this towards the issues in this case and not pediatric psychiatry.

(A short break was taken.)

Q. (By Mr. Barrett) Doctor, these questions do have a point, and I'm not trying to dwell on it, and we are going to move on.

(Record read.)

A. Oh, I agree that we all accrue judgment.

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Q. Do you agree that that's one of the reasons that laws generally treat young children who commit crimes differently from grown-ups who commit those crimes?

MR. SHEFFLER: Objection. Dr. Hilsman is not here to testify about the Legislative enactments with respect to the penal code of Mississippi.

A. I don't know. I assume, but I don't know for sure. That's almost a lay opinion, I guess.

Q. (By Mr. Barrett) Well, we don't put 10 year olds in Parchman, do we?

A. Sure.

Q. This is so, is it not, because we, as a civilized society, recognize that even if a child knows the facts that he lacks the judgment to deal with those facts; do you agree with that?

MR. SHEFFLER: Objection, unless you specify what you mean by child, unless specify what you mean by facts and unless you specify what you mean by when?

A. Yeah, I'd have to defer that simply because you and I both know there are children tried as adults for certain crimes.

Q. (By Mr. Barrett) 10 year old, 10 year old child that breaks in a 7-11?

A. I really don't know enough about the form of the law and the intent to answer that. I don't know why

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honestly.

MR. SHEFFLER: That is an answer. If you don't know, you don't know.

Q. (By Mr. Barrett) Do you agree that there are some adults who lack the judgment to make responsible or rational decisions even if they've been given the facts?

MR. SHEFFLER: Is this under the penal code now are we talking about, Mr. Barrett, again, or is this a new question? Object to the form.

A. Phrase it one more time for me.

(Off the record.)

(Record read.)

A. Define for me what your definition of judgment is.

Q. (By Mr. Barrett) Well, we're taking your deposition, Doctor, so let me ask -- that's a good question. How do you define "judgment"?

A. From a psychiatric point of view, judgment is the ability to assess a situation and make what you would consider a rational response to that situation, such as place, smokes starts coming in here, somebody's going to get up and say, "There's a fire." You see a letter on the street that has an address on it, you'd probably pick it up and put it in the post office if it hadn't been mailed. That's what psychiatric judgment is.

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Q. And that's what I mean by "judgment" as well.

A. Yes, there are no doubt people whose judgment is impaired to the point that they cannot make a rational decision.

Q. Is part of your job to treat some of these people; is it not?

A. True.

Q. Do you agree, for example, that the Social Security Administration has set up programs and regulations to identify and help people who are mentally incapable of holding a job and mentally incapable, even, of handling their own financial affairs?

MR. SHEFFLER: Objection. We have not produced Dr. Hilsman today to be an expert to give testimony with respect to the bases or rationale for the Social Security system and disability payments.

Q. (By Mr. Barrett) Answer the question, please.

A. People -- my working knowledge is people are evaluated by Social Security branch to determine whether or not they suffer from mental illnesses that will incapacitate them to work, and that they may be considered competent to manage their funds or not competent to manage their funds.

Q. But the Social Security Administration makes a judgment about that on people all the time; does it not?

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MR. SHEFFLER: Objection.

A. I assume.

MR. SHEFFLER: Let me caution you, Doctor, don't assume. You're here to today to give expert opinion as to those areas of your expertise and give factual testimony to those areas for which you have factual testimony if so asked.

Q. (By Mr. Barrett) Dr. Hilsman, Anderson Smith was one of those people considered by the Social Security Administration to be mentally incapable of holding a job; was he not?

A. I do not know that.

Q. He was also considered by the Social Security Administration as being incapable of handling his own financial affairs; is that not true?

A. I was not aware that Social Security made that statement.

Q. Were you unaware that the Social Security Administration or do you know whether or not the Social Security Administration for many years paid him a disability check and paid it to his mother for his benefit?

A. I was aware that the Army or through the government did, but I was unaware that there were -- that -- I was unaware specifically that there were two checks

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that he received.

Q. Are you aware of that now or are you saying you still don't know?

A. I'm assuming that's true. I don't know --

MR. SHEFFLER: Don't assume anything Mr. Barrett says is true or don't assume it's untrue. Don't make any assumption that --

A. I do not have --

MR. SHEFFLER: -- Mr. Barrett has any font of factual information relevant to this case.

A. I would be happy to look at those records if you want me to.

Q. (By Mr. Barrett) No, it's not -- tell me what you know about what government agencies had declared him to be mentally disabled, what government agency or agencies, what you know about that.

A. The only thing in reference to that question that I'm aware of is that the Army or the VA system awarded him a percentage of disability based on his illness and apparently that that would, from time to time, fluctuate in percentage of total body disability.

Q. Is that it?

A. Uh-huh.

Q. Sir?

A. That's it.

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Q. Do you know whether or not any court in Mississippi ever declared him to be judicially incompetent, declared Anderson Smith to be judicially incompetent?

A. I do not have that information.

Q. Would you think that's important information?

A. All information is important.

Q. All information is not relevant to this case, though, and so maybe I asked the question wrong. Do you consider that information relevant to this case?

A. It could be, yes.

Q. How could it be, what way? Would that change your -- affect your opinions in any way?

A. I am not --

Q. If it were so, if it were so.

A. I don't know. It would depend, I suppose, on the circumstances, and I'm not honestly sure what you mean by the statement you just made, he was adjudicated to be --

Q. To be a non compos mentis, do you know what that means?

A. I assume, yes.

Q. What does it mean to you?

A. Means that he is incapable of -- by virtue of his mental illness of being responsible, legally

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responsible.

Q. Well, let's assume that some court, whatever court that would be -- have jurisdiction and responsibility of making that decision for him made that decision, would that in any way affect your opinions in this case?

MR. SHEFFLER: Objection to form, unless you establish that Dr. Hilsman knows what the court means when it uses those terms. You haven't established that, so that's the basis for my objection to the question.

Q. (By Mr. Barrett) Did that attempted coaching --

MR. SHEFFLER: That was no attempt to coach. If I was going to coach him, I would coach him more directly.

Q. (By Mr. Barrett) You're doing fine without Mr. Sheffler.

A. I am certainly aware of times when this man was so blatently psychotic that he would have met such standards, so to have that documented as long as they would have fit the times that I'm aware of that he was -- he was suffering acute psychiatric embarrassment that would have -- I can't imagine how it would have an impact.

Now, if there -- for instance, just what could affect, if you could produce some document that would reflect change, that he was assumed competent and then

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incompetent, say immediately prior to his '85 - '86 admission, sure. I mean, there are places where that would certainly have a relevance, but to answer that blindly, I don't know. I mean, one thing about me, I am capable of changing an opinion if data is presented to me that would rationally change it.

Q. I believe you are.

A. I would try.

Q. Do you know whether or not he ever -- "he" is Anderson Smith.

A. Uh-huh.

Q. Ever had a court-appointed guardian to look after his affairs?

A. I do know that he did have and --

MR. SHEFFLER: Just answer the question.

A. Yes.

Q. (By Mr. Barrett) And what else were you going to say?

MR. SHEFFLER: Instruct the witness not to answer. You are pose questions, he answers them. You posed the question, he answered it. What's the next question?

Q. (By Mr. Barrett) Go ahead.

A. I was simply going to say he had two to my knowledge, two guardians.

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Q. What periods of time did he have guardians? Who were they and what periods of time to the extent you know?

A. I do not know the precise dates. I know that his -- that, as I understand it, that he had a guardian appointed to him following his leave from Tuskegee, whichever, the psychiatric hospital in Alabama, name I'm sure is in there.

Q. Tuskegee.

A. And he continued, to my knowledge, under some form of guardianship until his death, but the precise dates of that or when, as I understand -- and again in a very vague way, that his original guardian either became too aged or died or whatever, and another individual was appointed but that he retained such guardianship until he died.

Q. Do you know about any other guardianship ever being established for him?

A. I don't.

Q. Tell me what you do know. Start with -- tell me what you know about Anderson Smith's life concerning his -- well, any way you want to, and just --

MR. SHEFFLER: No, no.

Q. (By Mr. Barrett) Give us a -- do you know when he was born?

MR. SHEFFLER: That's a good question.

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A. 1922, I think, August -- I can't remember.

Q. (By Mr. Barrett) Do you know when he entered the Army?

A. '43, I believe. I mean, these are dates.

Q. That's fine.

A. You are doing a memory test on me now, and I admit my middle-aged memory is not the best.

MR. SHEFFLER: If you want to refer to any records, Doctor, you certainly have the right to do so, let me remind you.

Q. (By Mr. Barrett) what was the state of his mental health when he entered the Army to your knowledge?

A. To my knowledge, it was assumed acceptable to Army standards. I hate to use the word "normal", but for lack of a better word, I would assume normal.

Q. When did he first, to your knowledge, exhibit some mental incapacity?

MR. SHEFFLER: Objection. To the best of your recollection. Again, if you you want to refer to records on any of these questions, Doctor.

A. As I recall, it was when he was getting ready to re-up for his second hitch, and again, I'm thinking that would be '45, '46, somewhere in there.

Q. (By Mr. Barrett) That's right. And what are the salient things that you remember about the course of

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his mental illness after that, just the salient factors that you think are important.

MR. SHEFFLER: Objection. For the rest of his life, is that the question?

Q. (By Mr. Barrett) Take it for the next five years.

MR. SHEFFLER: From 1943 to 1948 is the question.

MR. BARRETT: No, no.

MR. SHEFFLER: '46 to '51.

A. He was hospitalized and diagnosed as having paranoid schizophrenia.

Q. (By Mr. Barrett) And do you know what happened to him after that?

A. He was --

MR. SHEFFLER: Objection.

A. I mean, I -- I assumed -- and again, I'm not supposed to assume.

MR. SHEFFLER: If you don't understand the question, ask him to tell you specifically what he means by what, when after.

A. Well, what I was going to say was that he left the service.

Q. (By Mr. Barrett) Do you remember about what year that was?

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A. No, I don't. I do not.

Q. Do you know where he went after he left the service?

A. I know he was hospitalized for certainly a period of time. I know he was with his mother in that interim. The records are really quite good or that were furnished to me, they really were quite good just plain period from that first admission all the way up until the early '50s, they're excellent.

Q. Do you know what happened to him during the 1950s?

A. Again, I'm not --

Q. During the course of his mental illness.

A. I know he had several psychiatric admissions, several periods of when he came home and stayed with his mom, periods in which he was ill and periods in which he was not ill.

Q. What is the DSM-III-R?

A. The Diagnostic and Statistic Manual, the third edition, revised volume.

Q. Published by the American Psychiatric Association?

A. Yes, or certainly in conjunction with the American Psychiatric Association.

Q. The thing it says on it --

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A. Right.

Q. You are a member of the American Psychiatric Association; are you not?

A. Correct.

Q. What's the purpose of the DSM-III-R? What does it purport to be?

MR. SHEFFLER: Objection, document speaks for itself?

A. It's a diagnostic manual, manual to aid clinicians in making psychiatric diagnoses.

Q. (By Mr. Barrett) It's a basic reference for the psychiatrist, is it not?

A. I would say so.

Q. In your opinion, is it an authoritative reference work for psychiatrists?

MR. SHEFFLER: Objection.

A. Yes.

Q. (By Mr. Barrett) Do you use it in your practice?

A. Yes.

Q. Do you use it often in your practice?

A. Yes.

Q. Is it the most important reference work that you have?

MR. SHEFFLER: Objection.

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Q. (By Mr. Barrett) For your every day practice?

A. No, it's not the best, no, but that's not what it was designed to be.

Q. What was it designed to be?

A. It was -- really, the design or the intent was to legitimize various diagnoses, so that if I called you a something in Orlando, Florida, that I would call you the same thing if I was a psychiatrist in Tuscon, Arizona. In an attempt to define standards of diagnoses so that there would be better understanding of what those diagnoses were, such obviously that you could define the population and define a treatment that was most effective, and each one of these, as you know, there's been a III-R, there obviously was III and a II and a I, and there's a IV to be, so they're under, I guess what you would say, constant revision. They're not an finite document.

Q. The current DMS in use is the volume III; is it not?

A. III-R. III came in '80 and R about the mid-'80s.

Q. You are -- I didn't go into your qualifications, but you are a medical doctor; are you not?

A. Correct.

Q. What, in your opinion, as a medical doctor is the greatest cause of lung cancer in the United States?

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MR. SHEFFLER: Objection.

A. The inhalance of carcinogenic material which would be described in most textbooks as its source from cigarette smoke.

Q. (By Mr. Barrett) Does cigarette smoke cause lung cancer?

MR. SHEFFLER: Objection.

A. I don't know. I don't think anybody knows.

Q. (By Mr. Barrett) What is the greatest cause of emphysema in the United States?

MR. SHEFFLER: Objection.

A. I would answer it the same as I did to the other question, ingestion of cigarette smoke.

Q. (By Mr. Barrett) What is the greatest cause of heart disease in the United States?

A. I'm not sure. I'm not sure if it -- it would be a close one there, whether it would be diet or lack of exercise or genetics or the ingestion of -- of cigarette smoke. That would be a toughy. Probably get some disagreement there.

Q. Moving along on your report that you gave, look at number 3 where you said -- you gave the opinion that"...nothing in cigarettes prevents these individuals from deciding to quit smoking or from successfully acting upon a decision to quit smoking."

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A. Correct.

Q. But specifically were these your words or were these words that were suggested by the tobacco company attorney?

A. My words would have been so close to this, and I can't tell you if they were or not, it is my opinion that there is nothing in cigarettes that would keep a person who desired to stop smoking from stopping, period.

Q. You're not saying that nicotine is not an addictive substance, are you?

MR. SHEFFLER: Objection.

A. I don't think you're going to find "addictive" in that manual, and if we're going to stay to the manual, then I -- then "addictive", you're going to have to define for me.

Q. (By Mr. Barrett) Is nicotine found in cigarette smoke?

A. Correct.

Q. What are the qualities -- what, if any, qualities does nicotine have that would tend to cause a smoker to want to continue to smoke?

MR. SHEFFLER: Objection to that question as ambiguous and difficult to understand.

A. Nicotine can stimulate pleasure, can stimulate the area in the brain that is perceived as pleasure.

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Q. (By Mr. Barrett) How do you define "addictive substance", the phrase "addictive substance"?

A. I don't. I mean, it's not -- at this point in time, the word "addictive" is really not used in the nomenclature, and it has such colloquial overridings that I'm going to dodge that one. Dependent is the word I think that you may be searching for. I mean, that's the 1993 word for what I think you're talking about, but I don't know.

Q. Have you ever smoked?

A. Oh, yes.

Q. Do you smoke now?

A. No.

Q. When did you quit?

A. I quit in April a year ago.

Q. Was it difficult for you to quit?

A. Yes.

Q. Why was it difficult for you to quit?

MR. SHEFFLER: Objection to the question.

A. I wanted a cigarette. Cigarettes were pleasurable, the effect that smoking gave me was pleasurable. I enjoyed it.

Q. (By Mr. Barrett) Were there any physiological effects of nicotine that you know about as a medical doctor?

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A. Oh, I know the basic physiological effects of nicotine.

Q. Does that create a craving to continue to smoke?

MR. SHEFFLER: Objection, unless you define the word "craving".

A. Certainly I think anybody with common sense say that smokers desire to smoke another cigarette. Craving, you know, is, again, one of those colloquial words that has a lot of different meanings. I would say that the chemical nicotine, once it reaches nicotine receptors in the brain, those receptors, once stimulated by nicotine and once the pleasurable feeling is arrived at, however you want to describe that, yes, a person is going to want to, in all likelihood, reproduce that feeling.

Q. (By Mr. Barrett) So I take it that what you're saying when you said that nothing in cigarettes prevents somebody that wants to quit smoking from successfully stopping --

A. Uh-huh.

Q. -- what you're saying is that it is possible for a human being to quit smoking even though there is nicotine in cigarettes that has habituating or dependence creating qualities?

A. That is correct.

MR. SHEFFLER: Wait a minute. Is that the

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question? I object to the question, and I would like to have the answer stricken. Answer was given before my objection. Please wait until I can register my objection before you answer.

Q. (By Mr. Barrett) A good percentage of the people who try to quit are successful, aren't they?

MR. SHEFFLER: Objection. Good percentage of the people who smoke or try to quit smoking?

Q. (By Mr. Barrett) Yes.

A. You've got me on "good". You give me numbers.

Q. Do you know the numbers?

A. Of --

Q. Persons who attempt to quit.

A. I think I do.

Q. Okay. What do you think those numbers are?

MR. SHEFFLER: Now, this is an objection to the form.

Q. (By Mr. Barrett) Go ahead, Doctor.

MR. SHEFFLER: Is this question percentage of people who try to quit smoking.

MR. BARRETT: Question is what it is.

MR. SHEFFLER: Could we have the last question read back, because I don't understand what it is, and I need to understand, too.

(Record read.)

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MR. SHEFFLER: Do you understand the question?

A. If the question is of the number of people, if you took a hundred people who were smokers and attempted -- and took that hundred and they stated that they wanted to stop, how many of those people, say at a year, would have successfully stopped, I think that figure hovers around a third, some would say less, some would say more.

Q. (By Mr. Barrett) A third who?

A. Are successful.

Q. In quitting.

A. If you further look at that outcome, it is largely determined by the resources that the quitting person chooses to quit, such that those can be awful skewed figures. If you look at the people who enter a self-help program to quit, who go to follow-up meetings, who actually try, obviously endeavor to do this, those figures are obviously much higher than someone who makes say a New Year's resolution on the first or Anti-Smoke-Out Day or whatever, so they're very variable, but I think about a third would be close to what is recorded in a lot of psychiatric literature.

Q. And so the other side of that is that a good percentage of people who try to quit are unsuccessful; is that correct?

MR. SHEFFLER: Objection to the use of the word

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"good" and objection to what you mean by "successful".

A. They reassume nicotine intake.

Q. (By Mr. Barrett) So the answer is yes?

A. No.

MR. SHEFFLER: The answer is what he said it was?

A. Because there's a difference there.

Q. (By Mr. Barrett) What's the difference?

A. Well, unsuccessful, there are people who would simply change their minds and say, "I don't want to quit, or I don't want to quit now, or I choose not to quit or this has come up or that's come up," so to say that it's unsuccessful I think is somewhat presumptuous. To say that they returned to the ingestion of nicotine through smoking is correct.

Q. Well, what percentage do you think are there of people who legitimately try to quit smoking, attempt to quit that are unsuccessful?

MR. SHEFFLER: Objection. Unless you define what the word "legitimately" means, I think the question is unanswerable.

Q. (By Mr. Barrett) You understand that's a follow-up to what you said, don't you, doctor?

MR. SHEFFLER: He may understand it but the record is unclear. I object to the use of the word

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"legitimately".

A. You would have to define those populations a lot more specifically, what -- because what you're really measuring -- at least in my opinion, what you're really measuring here is a person's motivation, and motivation versus pleasure is always an interesting confrontation.

There are any number of things that can affect motivation, and there are certainly any number of things that can affect a person's perception of pleasure, desire to seek pleasure, so outside of really nailing down the parameters of that, I'd have to stay with that kind of hovering vague third.

Q. (By Mr. Barrett) Doctor, look at number 4 there, opinion and I'm quoting, "the decision to smoke is a personal one, and it's based upon a variety of factors whose significance varies from individual to individual." I take it that's just what you were talking about a moment ago.

A. Correct.

Q. Let's go over these factors. You listed several of them just above that as you said each individual's personality, value systems, cultural and social environment, age and other circumstances; is that right?

A. Correct.

Q. What do you mean by his personality? How does

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that affect --

A. Well, some people are probably -- people's personality often defines their perception of attenuate risk. There are people by personality, nature, would be more risk takers. There are people who would be the obvious corollary to that.

Certainly there are cultures that you could say had a different perception of risk or a different way they would address the concept of risk, social environments, certainly people who appear, at least, to come from areas, social areas where cigarette smoking is more indigenous tend to smoke more.

People who come from social areas where the negatives or the negative attitude surrounding cigarette ingestion would be quite high, they would have probably a lower risk. I think that has certainly in some of the literature been proven.

Age, we know that age certainly has something, precise areas here we might not know, but age probably has something to be involved in the concept of risk that, using your concept, certainly adolescence is a time where people feel largely that they are in vulnerable. You get to be 35 or 40 and you know clearly that you're not in vulnerable. Personally, part of the reason that I chose to quit smoking I'm sure was based on my age, that I

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decided that in my mind that risk was no longer justified by the pleasure it was bringing me. When I was 29 years old, it didn't seem at that age to be as important as it does now, so I think age certainly, just from pure common sense, plays a part in many decisions, certainly the decision to choose to attend to certain factors, including risk or not to attend to them.

Q. You say other circumstances, what about the amount of judgment that the individual has? Is that a factor?

A. It certainly could be.

Q. Okay. Do you agree or maybe we've already agreed that some people have been given more judgment than others?

A. Correct.

MR. SHEFFLER: Objection.

Q. (By Mr. Barrett) What is your opinion of Anderson Smith's judgment?

MR. SHEFFLER: Objection, unless you specify the time, what time in his life, excuse me.

A. I think that is -- you must specify the time in his life.

Q. (By Mr. Barrett) Would you tell me at various times, give me your opinion of Anderson Smith's judgment as you understand it at various times.

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MR. SHEFFLER: Objection. That is completely impossible question to answer. Specify the times, Mr. Barrett, and ask him specifically with respect to the time periods you're seeking information.

Q. (By Mr. Barrett) Go ahead, Doctor.

A. I don't know if I can do that without -- the reason for that is that psychiatric judgment in the face of a person who suffers from schizophrenia is a very variable phenomena that may vary from day to day and not just month to month or year to year, and in fairness, those medical records don't do an adequate job in addressing that question very well at all, so I couldn't answer it any better than that.

Q. So you don't know?

A. No, not in the sense of a day to day what his judgment was, you know, January 8th, 1949, versus October 5th, 1967, I do not know, no, I do not.

Q. Well, do you know as to any particular months or years that -- I mean, are you prepared to say that -- what are you prepared to say about his judgment at certain times?

MR. SHEFFLER: Objection. There's two questions there. If he's asking you if there's any month or any year in his entire life when you don't have a judgment, then I think your answer has to be no, you cannot answer

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the question. I object to the form of the question, and I'd further like to say, Don, I think this is inappropriate to examine a witness by saying, "Just tell me anything you know about any period of time in this man's life, and you define it and tell me what you know." That's not a question -- even in a discovery deposition, not anywhere to appropriate, and you know better.

Q. (By Mr. Barrett) Go ahead, Doctor.

A. I could, I'm sure, examine those records and find for you some document in there during one of his psychotic episodes that -- delineated data that would certainly make me suspect of his judgment on that day. The -- corollary to that, of course, is that you have rather massive periods of this man's life where you have no reason to believe he does not have good judgment, and the unfortunate thing is, as you well know, whenever you review the records of someone who are no longer living is all you have are those records or other pieces of evidence which I don't have.

Q. Do you have any other pieces of evidence besides the records?

A. No, huh-huh, I do not, and that would really be helpful, particularly in reference to the concept of judgment, but if you're going to use concept here, schizophrenia is not a disease of judgment, and certainly

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when a person is actively psychotic, their judgment is impaired. Any rational person knows that, but to assume when they are not so actively psychotic, their judgment may be as good or better than ours, and even during an active episode of psychosis, in certain areas, their judgment would be as good as ours, so it's really very person-to-person, time-to-time specific.

Q. Let's leave the question of judgment for a little while.

A. Okay.

Q. Do you agree that some people are given more intelligence than other people?

A. Yes.

Q. And do you agree that the amount of intelligence a person has will be one of the factors that go into this decision about smoking?

MR. SHEFFLER: Objection. Objection, unless you tell us what you're talking about by degree and how it impacts upon smoking.

A. That is a little vague for me.

Q. (By Mr. Barrett) I can clear that up. You had said up earlier the decision to smoke is a personal one based on a variety of factors, and I was just asking is intelligence one of those factors.

MR. SHEFFLER: Objection.

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A. Let me answer it this way: I consider myself fairly bright, and I smoked, and one can take that for what it may be. I know of other people who have IQs that would be below a hundred who have apparently chosen to smoke at some point in their life. The one thing that technically both of us have in common, and I'm thinking of one person in particularly, is we both stopped at the same time, so I'm sure intelligence affects everything some way, but whether it specifically affects this question and to what effect it has, I don't really know.

Q. (By Mr. Barrett) Intelligence, the definition of intelligence is simply the capacity to acquire and to apply knowledge; is it not?

A. Uh-huh.

Q. That's the sense I'm using it here. Would you agree that -- let me ask you this: What have you learned about Anderson Smith's capacity to acquire and to apply knowledge?

MR. SHEFFLER: Objection unless you specify --

Q. (By Mr. Barrett) From looking at the records.

MR. SHEFFLER: Unless you specify when, he's already testified his information comes from the medical records.

A. The only or the thing I should say that sticks out in my mind is a note, I cannot remember if it's by a

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psychiatrist or social worker, that says that he went through the seventh grade and that Anderson Smith defined himself as someone who had difficulty with reading and dropped out of school.

Q. (By Mr. Barrett) Said he hated it as a matter of fact?

A. As you say that, I think I do remember that. That, unfortunately, is not a -- that is the closest thing that I found that you could even begin to reference some vague concept of intelligence. I could find no specific in at least my records of any psychological testing done, any electrical IQ test, et cetera, and the difficulty even with that one statement is that it's kind of parenthetically used I think in the records or as I recall it to get some concept of education intelligence is that we know now, of course, we didn't know then, that there are a lot of people that have specific learning disabilities with reading, so we really don't know specifically, and particularly when this man was a young man, say before the age of 45, that much about his intelligence.

Q. One thing we know from the records is that if he had difficulty in reading, he would have difficulty in acquiring the knowledge that came from magazine articles and books and any knowledge that would be contained in the

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printed word; is that a fair statement?

MR. SHEFFLER: Objection. Objection to the form of the question and the assumption therein, that he was -- had difficulty in reading throughout his life.

A. I don't know.

Q. (By Mr. Barrett) Do you think you can understand books if you can't read, doctor? That's all I'm asking.

MR. SHEFFLER: Objection. That's argumentative. You haven't established when he had difficulty reading, Don, and that's what I was objecting to. That's an argumentative question.

A. If the truth is that statement that is found in the medical records, that he had difficulty reading and that he quit school in part because of that or that's certainly the way I think anybody would read that, then surely it would have been harder for him to read than someone who didn't have difficulty reading. We do not, of course, know what effort he may have produced or not produced or what other attempts at engendering the ability to read he may have had through the remainder of his life. That's the only note that I know that addresses that in the chart.

Q. We're still talking about the decision -- your opinion that the decision to smoke is a personal one based

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on a variety of factors?

A. Uh-huh.

Q. Now, when you say to smoke, I assume that means not only to smoke the first cigarette but to continue to smoke after you started. Did you mean that?

A. Yes.

Q. Well, would you then agree that another factor, just one of the factors would be these dependence-creating qualities of nicotine?

MR. SHEFFLER: Objection to the phrase "these dependence-producing qualities of nicotine," objection to the assumption that those qualities exist.

A. It is my opinion that nicotine, once it crosses the blood brain barrier, once it reaches its receptor site that one of its affects is pleasure and that that effect is desired by the user and is part -- part of the process that would go into whether or not this person would continue to use this mechanism of receiving pleasure.

Q. (By Mr. Barrett) So the answer to my question is?

A. Well, I have a little bit of --

MR. SHEFFLER: Let him phrase the question and give me a chance to state my objection before you testify.

Q. (By Mr. Barrett) The answer to my question is the nicotine contained in cigarettes, one, just one of the

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factors that affect the decision to smoke as you stated in paragraph 4?

MR. SHEFFLER: His answer to your question was what his answer was, Don. If you're asking another question, that's fine, but don't characterize his testimony in an erroneous fashion. Object.

A. Nicotine is part of the equation, correct, in my opinion.

Q. (By Mr. Barrett) In your opinion, assuming everything else to be equal and assuming that you have two people, one of high intelligence and one person obviously and clearly less intelligent, which of these two would be more likely to resist these qualities of nicotine and why?

MR. SHEFFLER: Object to the form of the question. If you can answer that question, Doctor, try.

A. I don't think it would make a bit of difference.

Q. (By Mr. Barrett) Do you recognize nicotine withdrawal to be an organic mental disorder?

A. I recognize it's in DSM-III. There's a lot about that particular -- if you'll allow me here a little bit of leeway, number one, it is the only alleged psychoactive substance that's listed that doesn't have abuse. There is no such thing as nicotine abuse.

Q. Nicotine --

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A. Abuse. Of all the other psychoactive substances, there is such a thing as nicotine abuse -- I mean of psychoactive substance abuse such as alcohol or amphetamines or whatever, not in III. The difficulty here is that, at least for me, is that I do not doubt that there is an observed series of events that occur in an individual after they discontinue the ingestion of nicotine. I mean, those are -- some are certainly measurable such as heart rate going down. In most individuals, that occurs. I mean, that is a specific finding.

The remainder of those, they're such a -- as pervious in III-R, there's such a wide variance of subjective, and how much of this is physiologic, if you look at the listing as what they use as parameters, things like irritability, desire for the substance, weight gain, these are things that are not very clearly measured such as heart rate. Of all of the phenomena found in DSM-III-R, the withdrawal syndrome that you described, the only thing in there that is really acutely measurable is heart rate, so my gripe with that is that, in my opinion, those events occur.

I am not sure that I agree -- and there are others other than myself that agree that that should be the specific mechanism of nomenclature to describe that.

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A lot of probable social pressure was placed on that. As you're probably aware, there will be one more category in DSM-IV, caffeinism in many textbooks today describe those two disorders in the same chapter, and if we're going to look at this stuff and describe it as organic withdrawal syndromes and such as that, we probably need to know that what we're really talking about is something that's a lot more like caffeine than anything else, and has a lot of subjecticity in regards to these various symptoms that are demonstrated that have been called this organic withdrawal syndrome, so I have some gripe there. I agree it's in there, I just --

Q. Do you agree that nicotine withdrawal -- do you disagree with having nicotine withdrawal listed as an organic mental syndrome disorder?

MR. SHEFFLER: Objection.

A. Probably I do. I object to it on the basis that scientifically if they were going to include nicotine withdrawal absence syndrome, however you want to characterize that, then they darn well should have addressed caffeinism at the same time and -- because they're basically very similar withdrawals "documented," at least if you're going to use that paraphrasing, very similar only in their large major differences in time of when the "symptoms" begin. Caffeine, of course, being a

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longer acting drug, it takes longer for this to occur. I have trouble in --

Q. Isn't there a big difference also between the cigarettes and coffee, a fundamental difference?

MR. SHEFFLER: When you light and when you drink? Objection to the question, fundamental in what way? That one's white and one's black?

Q. (By Mr. Barrett) That one them kills a lot of people and the other one doesn't?

MR. SHEFFLER: Objection.

A. That doesn't have a darn thing to do with that syndrome. You're talking about two completely different bananas and pears here.

Q. (By Mr. Barrett) Okay.

A. The phenomena of discontinuing nicotine, whether it be through nicotine patches, cigarettes, snuff, you know, chewing tobacco, whatever, I would agree with those findings, or that list of eight or nine or however many there are, as being fairly representative of the things you see, and I think anybody with common sense would, but there's so many various factors that could go into making up the majority of those things behaviorally, to just blanket them under nicotine may be taken a little bit of scientific poetic license there, and to not include caffeine, which is clearly so similar in terms of effect

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and, then later to add it in DSM-IV kind of smacks of, you know, who do you believe here? It's not a diagnosis, but in July it's going to be a diagnosis. It didn't exist in 1989; it did exist in 1993. You have to look at those things as to some degree being documents that have movement and change and are not finite or God's testimony to man, cause they do change dramatically from edition to edition.

MR. SHEFFLER: Doctor, let me counsel you to answer the questions as posed to you.

Q. (By Mr. Barrett) It may not be God's testimony to man, but it's the American Psychiatric Association's current testimony to psychiatrists; is it not?

MR. SHEFFLER: Objection. American Psychiatric testimony to psychiatrists? Objection to the form.

A. It's a manual of diagnostic concern. To give you a for instance, you cannot use those diagnoses to bill the government for a Medicare patient. They don't accept those diagnoses. They do not attenuate them to be representative diagnoses that you can treat or bill a patient for. In their eyes, they do not exist. They have no scientific reference for purposes of treatment or recovery of financial benefit from treatment.

Q. (By Mr. Barrett) That's a good point. Have you ever counseled patients who were trying to quit smoking?

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A. I must have, but I don't remember. I counseled myself.

Q. Why do you say you must have?

A. Because at one point in my life, I ran a -- kind of was the medical director of a free-standing mental health center, and we treated everything known to man, and for years I also actively taught on a day-to-day basis or certainly week-to-week basis at University Medical Center that would have had certainly within that some exposure directly with such. But I cannot recall, certainly haven't done any direct counseling in well over 10 years.

Q. Do you remember with what degree of success you had in the counseling you did?

MR. SHEFFLER: Objection, if he can't remember --

A. No.

Q. (By Mr. Barrett) Do you agree that some people are better than others at overcoming nicotine withdrawal?

MR. SHEFFLER: Objection. He's already testified what he's testified about nicotine withdrawals and his use of the term. Object to the hypothetical, assumption included in the question.

A. I think I said motivation is probably a real important factor, somebody wanting to stop. That appears throughout the literature.

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Q. (By Mr. Barrett) Is one of the signs of paranoid schizophrenia a lack of motivation?

A. No.

Q. Is one of the signs of schizophrenia a lack of motivation?

A. Say that again.

Q. Is one of the signs of schizophrenia a lack of motivation?

MR. SHEFFLER: Lack of motivation to what? Objection.

A. The way you've worded that, the answer is no. However --

MR. SHEFFLER: Again --

Q. (By Mr. Barrett) Go ahead, Doctor, explain your answer.

MR. SHEFFLER: Answer the question, Doctor. Please do not go beyond the --

Q. (By Mr. Barrett) Next question is please explain your answer.

MR. SHEFFLER: Fine. If you need to.

A. That is not a di -- a sign or symptom that needs to be found in schizophrenia to make the diagnosis. There are individuals that have schizophrenia. There are individuals that have literally every single psychiatric diagnosis where you can find modifications of level of

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volition, and certainly it would be true in the diagnosis of schizophrenia as well as any other psychiatric diagnosis.

Q. (By Mr. Barrett) It would be true, what would be true? I didn't quite follow you.

A. That there can be variances.

Q. I'm not quite sure how that relates to motivation. Are you saying that lack of motivation is commonly associated with schizophrenia?

MR. SHEFFLER: Objection.

Q. (By Mr. Barrett) Let me ask --

MR. SHEFFLER: Ask it the right way.

Q. (By Mr. Barrett) Is lack of motivation commonly associated with schizophrenia?

MR. SHEFFLER: Good question, Don.

A. I would have to say what type are you describing, because it varies significantly from type to type, significantly.

Q. (By Mr. Barrett) Well, any of the types of schizophrenia that Anderson Smith may have been diagnosed with.

A. Paranoid schizophrenia typically does not have significant detriments and motivation or volition.

Q. Is it sometimes associated?

A. It may be.

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Q. Is paranoid schizophrenia the only type of schizophrenia that Anderson Smith was ever diagnosed with?

MR. SHEFFLER: Objection. To the extent you know, Doctor, and based upon your review of the records?

A. To the extent I know it is.

Q. (By Mr. Barrett) Is "nicotine dependence" -- and I'm using those two words in quotes -- an organic mental disorder?

MR. SHEFFLER: Objection.

A. As per DSM-III-R?

Q. (By Mr. Barrett) No, not necessarily. I mean, that's a different question.

MR. SHEFFLER: Object to the form.

Q. (By Mr. Barrett) Let me ask the first question, and then we'll get into the DSM-III-R later. Is nicotine dependence an organic mental disorder?

MR. SHEFFLER: As defined by DSM-III-R? What's organic mental disorder? Objection.

A. As defined by DSM-III-R it is.

Q. (By Mr. Barrett) Leaving aside DSM-III-R, is it an organic mental disorder?

MR. SHEFFLER: Objection, unless you establish that there is such a thing as organic mental disorder outside of DSM-III-R.

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A. And that's where I think you're caught, because I don't think that -- the way that nomenclature is stacked, it is a DSM-III-R term.

Q. (By Mr. Barrett) I see. What do you think an organic -- how do you define organic mental disorder? I'm going to get untrapped here, Doctor?

A. It is a mental disorder that would be based on organic embarrassment to the body, some trauma, infection, intoxication, et cetera, et cetera, to the brain of the central nervous system.

Q. Well, just in that general sense, then, is nicotine dependence such a disorder?

A. It is in DSM-III-R. It was not, however, before.

Q. Well, do you have an opinion, based on your own training and your own treatment of people and your own education and your own personal experience, perhaps, whether or not nicotine dependence as an organic mental disorder?

MR. SHEFFLER: Objection. The Doctor just said outside of DSM-III-R brain disorders do not exist. So if your question is is it in DSM-III-R, it is asked and answered three times now.

A. To the best of my knowledge, the only place you're going to find nicotine dependence in terms of any

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kind of disorder is going to be with the DSM-III and IV. I honestly cannot remember if it was in III or just in III-R, because my memory doesn't serve me that well at this point, but in III-R certainly it's listed.

You will not find it otherwise. Whether it existed or it didn't, I don't know. It exists as it is represented in DSM-III-R.

MR. SHEFFLER: Four times.

Q. (By Mr. Barrett) Look at number 5 there. You said the decision to smoke is an informed and voluntary decision.

A. Correct.

Q. You're not saying that this is true for every single individual in the United States, are you?

MR. SHEFFLER: Objection to the question unless you mean -- unless, again, because of the peculiar situation in Mississippi where 18 year olds and under are not allowed to make the decision, I would request that you direct your question to 18 year olds and over. Is that right? Direct your question to those individuals over 18 years old. Would you agree to do that, Mr. Barrett?

MR. BARRETT: Don't answer the question. Just stop just a second. Mr. Sheffler, I'm going to say for the record that this deposition is being taken pursuant to the Mississippi Rules of Civil Procedure. It is a

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discovery deposition. One of the discovery rules in Mississippi is that all objections are waived, save as to the form of the question, that's the only objection that you can make.

You have -- I don't know whether you've been trying to be intentionally disruptive or whether you just -- your native wonderful exuberance or what, but you're being disruptive in this deposition. Every single question I've asked, you've made a long speaking objection that suggests an answer to the Doctor, and if you continue to do it, for the record, I will seek sanctions of the court. I don't know what they'll be, but I think I'm entitled to some relief, and I'm going to seek it.

MR. BAILEY: Don, the rules of civil procedure contemplates that objections are waived except those that can be corrected or that the objection to them could be obviated at the time of the deposition. In other words, an objecting attorney can certainly preserve his record by pointing out the deficiencies in the question so that to give you the opportunity to ask an appropriate question so you won't be heard later to say that it's unfair when the court strikes the question and answer.

MR. SHEFFLER: In addition to that, let me represent to you, Mr. Barrett, that my objections were not couched in any way to be disruptive of this deposition.

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My natural exuberance, as you put it, is only a reflection of the fact that the frustration that I feel with respect to the questions that I believe that you have asked that are completely and utterly objectionable and do need to reflect my reasons for the objections, such as the assumptions that you build into your questions.

MR. BARRETT: Okay.

Q. (By Mr. Barrett) Now, we'll start over. You said that the decision to smoke is an informed and voluntary decision, and my question to you is: Are you saying that this is true for every single individual smoker in the United States?

MR. SHEFFLER: Repeat the prior objection from the former question.

A. I'm sure it's not.

Q. (By Mr. Barrett) You would agree that some Americans are not informed?

MR. SHEFFLER: Objection unless the question is directed to adult Americans.

A. I could certainly create some scenario that could encompass a person smoking and not having full, informed consent of all the risks, yes.

Q. (By Mr. Barrett) Okay.

A. It would be possible, I'm sure.

Q. Okay. Do you agree that there's a difference

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between, on the one hand, knowing that there is a reported risk of cancer, knowing that some people say that cigarettes cause lung cancer and on the other hand knowing that cigarette smoke really does kill "X" number of Americans per year or "X" percentage of heavy smokers?

MR. SHEFFLER: Objection. Would you read that question back, please? I think it's missing something.

Q. (By Mr. Barrett) Go ahead and answer the question.

MR. SHEFFLER: Read the question back because I got lost in all of this.

(Record read.)

MR. SHEFFLER: I object to the form of the question.

A. I don't know.

Q. (By Mr. Barrett) You don't know?

A. I don't know of any data to generate an opinion one way or another.

Q. What are the facts relating to cigarette smoke and disease that you contend that most smokers are informed about?

MR. SHEFFLER: Object.

A. Please word that for me one more time. This pager went off. I apologize.

Q. (By Mr. Barrett) What are the facts relating to

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cigarette smoke and disease that you contend that most smokers are informed about?

A. It's my belief that most smokers are aware that there are substantial reports of evidence that cigarette smoking would endanger you cardiovascularly, pulmonarily and certainly to the oral pharynx. I think -- I'm sure there's some percentage of Americans who don't know that, but it would have to be an awfully small percentage who have not been made aware of that series of discoveries.

(A short break was taken.)

Q. I had asked you earlier, Doctor, before we took the break what were the facts relating to cigarette smoking and disease that you contended that most smokers were informed about, and you answered the question. I want to ask you now a few specific questions to test your own knowledge about information on the subject.

How many smokers per day in the United States die from smoking.

MR. SHEFFLER: Objection to the assumption that any do.

A. I don't know.

Q. (By Mr. Barrett) Do you have any idea?

MR. SHEFFLER: Objection.

A. No.

Q. (By Mr. Barrett) How many smokers die from

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smoking each year in the United States?

MR. SHEFFLER: Objection to the assumption that any do.

A. I don't know.

Q. (By Mr. Barrett) Do you have any idea?

A. No.

Q. What kills more Americans each year, smoking or alcohol, including in that drunk driving?

MR. SHEFFLER: Objection to the assumption.

A. I have real trouble with the vagueness of this thing, smoking versus, and I just -- I can't answer that question.

Q. (By Mr. Barrett) You don't know?

A. I don't know if you mean people who smoke one cigarette a day, people who smoke four packs a day. You define smoking for me, and you define alcohol or alcoholism, and we'll sit down and talk on it.

Q. Okay. I will. I'm talking about people who have ever smoked one cigarette are smokers, up through people that smoke several packs a day, any smokers. That's what I mean when I say how many of them are killed each year from smoking.

MR. SHEFFLER: Wait, wait, objection until you ask a question.

A. Smoking never killed anybody. The alleged

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effects of smoking has -- certainly if you define that term for me again, but in my opinion smoking, per se, is a behavior and doesn't kill anyone. Now --

Q. (By Mr. Barrett) Okay. In light of that previous statement or answer by you, let me go back and ask this question: How many smokers per day die from cigarette smoke in the United States?

MR. SHEFFLER: Objection to the assumption.

A. I think I answered that, that I didn't know.

Q. (By Mr. Barrett) Will you change the -- you said something that smoking doesn't kill anybody, and I assume that you mean that cigarette smoke does; is that right?

MR. SHEFFLER: Objection, objection.

Q. (By Mr. Barrett) Is that what you meant?

MR. SHEFFLER: Objection to mischaracterization.

A. To answer your question, I do not know the answer that to question.

Q. (By Mr. Barrett) Let me clear the record to make sure that we're talking about the same thing. I'll just ask the question, and you give the --

A. Okay.

Q. How many smokers per day die from cigarette smoke in America?

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MR. SHEFFLER: Objection, asked and answered, and I also object to the assumption of the question.

A. I do not know.

Q. (By Mr. Barrett) How many smokers die from cigarette smoke each year in the United States?

MR. SHEFFLER: Objection, asked and answered and assumption.

A. I do not know the answer to that.

Q. (By Mr. Barrett) How many Americans, smokers or nonsmokers, die from cigarette smoke each year in the United States?

MR. SHEFFLER: Objection, asked and answered and assumption.

A. I do not know the number.

Q. (By Mr. Barrett) What kills more Americans each year, cigarette smoke or alcohol, including drunk driving in the alcohol-related deaths?

MR. SHEFFLER: Objection, asked and answered and assumption.

Q. (By Mr. Barrett) Which of the two kills -- categories causes the most death?

MR. SHEFFLER: Objection, asked and answered and assumes facts not in evidence.

A. I think the best way for me to answer that is to say I don't know the answer to that question the way it's

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worded.

Q. (By Mr. Barrett) Could you word it in a different way? Do you know of --

MR. SHEFFLER: Objection.

Q. (By Mr. Barrett) Is there some word that's giving you trouble there in the phrase?

MR. SHEFFLER: Objection. That's not his responsibility.

Q. (By Mr. Barrett) You seem to be suggesting that there's some word or phrase that you don't understand or that you cannot agree with.

MR. SHEFFLER: Objection.

Q. (By Mr. Barrett) Is there any such word or phrase?

MR. SHEFFLER: Objection to the form of the question.

MR. UPSHAW: Instruct the witness not to ask his own question. None of us need to ask questions for you, Don.

MR. SHEFFLER: The witness is instructed not to ask himself questions at the deposition, let Mr. Barrett ask the questions. Ask a question, Mr. Barrett.

Q. (By Mr. Barrett) Can you answer the question?

MR. SHEFFLER: Objection.

A. There is no specific point to your question

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there.

Q. (By Mr. Barrett) Then which kills more Americans each year, cigarette smoke or cocaine and crack?

MR. SHEFFLER: Objection, assumes facts not in evidence.

Q. (By Mr. Barrett) Or do you know?

A. I will answer that with the same answer as to the previous question concerning alcohol.

Q. Which kills more Americans each year, cigarette smoke or AIDS?

MR. SHEFFLER: Objection to the assumption.

A. I will, again, answer that in the same way.

Q. (By Mr. Barrett) And say what?

A. I -- I do not have a specific opinion of a yes or no, which kills more or less.

Q. Which kills more Americans each year, cigarette smoking or homicide?

MR. SHEFFLER: Objection to the assumption of the question, assumes facts not in evidence.

A. Again, I do not -- I do not have an opinion.

Q. (By Mr. Barrett) Which kills more Americans each year, cigarette smoking, on the one hand, or alcohol, including drunk driving, homicide, suicide, heroin and morphine, AIDS, fires and car accidents all put together?

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MR. SHEFFLER: Objection, assumption in the question.

Q. (By Mr. Barrett) Do you know the answer to that?

A. I don't have a formed opinion or an answer.

Q. Thank you. Dr. Hilsman, what percentage of long-term heavy smokers die from cigarette smoking or from cigarette smoke?

MR. SHEFFLER: Objection, again it assumes evidence -- facts that are not in evidence?

A. Rephrase that for me.

Q. (By Mr. Barrett) What percentage of long-term heavy smokers die from cigarette smoke?

MR. SHEFFLER: Objection.

A. I don't have an answer to that.

Q. (By Mr. Barrett) What percentage of smokers, in the sense that I used earlier of anybody who's ever smoked a cigarette, die from cigarette smoke?

MR. SHEFFLER: Objection.

A. I don't know the specific answer to that.

Q. (By Mr. Barrett) What are the odds that a long-term heavy smoker will die from cigarette smoking?

MR. SHEFFLER: Objection.

A. I'll continue with that I don't have an answer to that question.

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Q. (By Mr. Barrett) I will go back to your statement, number 5 there, where you said that the decision to smoke is an informed and voluntary decision?

A. Uh-huh.

Q. How do you define the word "voluntary" as you used it?

A. A person makes a choice that is done with their free will.

Q. Okay. But you agree, do you not, that nicotine withdrawal and nicotine dependence are factors that most smokers must overcome in order to quit smoking or do you not?

MR. SHEFFLER: Objection, objection. That question has been asked and answered extensively 23 minutes ago.

A. I believe a set of psychologic and physiologic events occur after nicotine in any shape, form or fashion is discontinued and that that is a period of time that anyone who is discontinuing these substances must process through.

Q. (By Mr. Barrett) Look at number 6 there, Doctor. "It is Dr. Hilsman's opinion that scientific or medical expertise notwithstanding, it is improper to supplant an individual's voluntary, informed decision to smoke or not to smoke with a contrary decision." Exactly

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what do you mean by that?

A. It was a bit stilted, I admit. My opinion of what that means, this is my opinion.

Q. Right.

A. Is that if a person makes a choice to smoke and medical evidence would indicate that that was certainly looked to be an unhealthy choice that they, nevertheless, have a right to participate in that choice as long as it's legal.

Q. In other words, you're saying -- apparently what that says, if you boil it down a little bit more is that it's legal to smoke.

MR. SHEFFLER: Objection.

A. Well, it is legal to smoke.

Q. (By Mr. Barrett) Yeah.

A. You could, I think, use the same theorem with alcohol consumption.

Q. Yeah.

MR. SHEFFLER: Same objection.

A. People may or may not choose to drink based upon what they may or may not think is evidence that would indicate its detriment, et cetera, but they still have a right -- as long as a substance is legal, they should be the ones that make that choice. There's no reason to believe that someone else can make that choice for them

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better.

Q. (By Mr. Barrett) Okay. In other words, it shouldn't be made illegal?

MR. SHEFFLER: Objection.

Q. (By Mr. Barrett) Is that what you're saying?

MR. SHEFFLER: Objection, objection. Now, wait a minute.

Q. (By Mr. Barrett) Is that --

MR. BARRETT: Wait a minute. Don't --

MR. SHEFFLER: Let me get my objection on the record. You continually mischaracterize the testimony with the phrase "is that what you're saying". If you have a question to ask, ask it without mischaracterizing the previous testimony.

MR. BARRETT: Read that back.

(Record read.)

A. That has nothing to do with what I'm saying I don't think.

Q. (By Mr. Barrett) You say it is improper to supplant an individual decision to smoke with a contrary decision. It's improper for whom to do it?

A. What I meant by that was that it is -- it is very easy to have data presented to you in a fashion that may look far more damaging than it actually is. For instance, you -- many smokers believe that it is

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inevitable, the way data has been given to them, that they will ultimately die of lung cancer, and that's, as you and I both know, patently not true, but if someone starts making the decisions as to what we can choose as pleasurable or non-pleasurable, I have a lot of difficulty with that.

I have a lot of difficulty with the idea that people don't have free choice and that anything that would supplant that free choice should be held in contempt.

Q. Well, who do you think has attempted to make this choice? Who are you talking about?

A. I didn't say that.

Q. Well, I'm asking you, who do you think?

A. I'm not. There are many things you do beforehand.

Q. Many things that who does?

A. I think people can anticipate that restraints, and certainly we've seen the beginning of restraints as far as the choice of smoking, places that one can smoke, and I'm not here to say one thing one way or another about that, but restraints are being imposed.

Q. Is that what you were talking about here about restraints being imposed on where people smoke?

A. No, the concept that people -- what I'm talking about here is you or no one else has the right to tell me

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specifically what pleasure source I can voluntary participate in, and I admit I choose or chose a minute ago to plant that with the concept of legality. And I'm comfortable with that.

Q. This is a philosophical opinion of yours, is that --

MR. SHEFFLER: Objection.

Q. (By Mr. Barrett) -- correct or not?

MR. SHEFFLER: Objection.

A. Well, it -- kind of a constitutional opinion, I think.

Q. (By Mr. Barrett) But it doesn't require -- this opinion doesn't require any medical or psychological expertise to form, does it?

MR. SHEFFLER: Objection.

A. No.

Q. (By Mr. Barrett) Thank you. Look at number 7, "Dr. Hilsman will testify about the mental disorder of schizophrenia and will discuss what is known about schizophrenia." Tell us what you're going to testify about that.

MR. SHEFFLER: Objection. Objection to the extent that no questions have been posed to Dr. Hilsman. I don't see how he can answer such a question.

MR. BARRETT: Well, you have a deficient 26(b)4

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response, and rather than file a motion for sanctions, I'm just asking -- I'm trying to fill it in for you. You're not allowed to say that somebody is going to testify about something. I want to know what he's going to testify, and I'm entitled to ask the question.

MR. SHEFFLER: If you want to ask him what is the mental disorder of schizophrenia, if you want to ask him what is the clinical course of schizophrenia, if you want to ask him what is known about schizophrenia, I have no objection. I do have an objection to you asking him what is he going to say at trial when he has never been asked a question with respect to trial.

Q. (By Mr. Barrett) Dr. Hilsman, you said that you looked over that and these are your -- you know, that you adopt this as yours. What did you mean when you said you were going to testify about the mental disorder of schizophrenia? That's all I'm asking.

MR. SHEFFLER: Objection to the form of the question.

Q. (By Mr. Barrett) Go ahead.

A. What I assume is certainly this man, having had schizophrenia, and assuming that certainly his illness would play a part in this trial that someone would ask me a question about schizophrenia, and I assume that I would testify concerning those questions that would be posed to

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me concerning the diagnosis of schizophrenia. What questions would be asked, and obviously what I will say will be based on what questions are asked me, and that, I guess, will be up to the individuals in this room.

Q. Well --

A. I have no prepared treatise to give to the court.

Q. Give us the highlights of what is known about schizophrenia?

MR. SHEFFLER: Objection. Objection. If you can answer the question, Doctor, please do so.

Q. (By Mr. Barrett) says here you're going to testify about what is known about schizophrenia. Now, I'm just asking you what are you going to testify -- what are the highlights you're going to testify about? Not a difficult question.

MR. SHEFFLER: Objection to the form of the question and objection to its overbreadth.

A. What I will doing basically is attempt, if asked, to paint for the jury a kind of working sketch of what this disorder is.

Q. (By Mr. Barrett) Would you do so for me right now?

A. It is a disorder of perception and thought and affect that affects --

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Q. What does "affect" mean?

A. Facial expression, mood, such as that, and that it's characterized by fairly clear cut symptoms that you can delineate from one region to another region, and that these symptoms, albeit not one particular etiology schizophrenia, but any number of probable disorders that mimic these symptoms can fairly well be characterized by kind of a blueprint sketch that would represent an individual as having characteristics as defined by DSM-III-R, and those largely would be, using their categories, an individual who had, within these parameters, certain phenomena that had to be delineated, one they would have to have two of the following, and that would be either they would have to have delusions, hallucinations, significant serious disturbances in their affect, very loose associations, catatonic.

Q. Excuse me, what does loose associations mean?

A. Their speech patterns not conjoining in a sensible fashion, that they'd start here and all of a sudden they might implant something, a complete no meaning to that sentence or a phrase, catatonic behavior and, of course, hallucinations. If a person has two of those phenomena for one week with a period -- or at least for one week or has extremely bizarre delusions, meaning misrepresentations, or a person has extreme prominent

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hallucinations, such as hearing a conversation by two voices exterior to your head discussing what you're doing from day to day or specifically telling you what to do on a running basis, that would be the effective criteria for one week of active illness, and obviously what that implies is that the person will be psychotic, that is that they will have hallucinations generally of an auditory sense, delusions meaning misrepresentations of material that are culturally unsound to entertain, and that that context of symptoms lasted at least one week, and that there would have to be a period, either before or after this constellation of active symptoms what are called prodromal or symptoms that lasted six months, and those prodromal or residual symptoms would be oddities of behavior, such as gathering garbage, social isolation, social withdrawal, various changes in mood or temperament, et cetera, et cetera, there's a long list, and that to manifest or be diagnosed as having schizophrenia, that this would not be due to an affective illness such as major depression or mania, that it would not be due to the disorder -- schizo-affective disorder, that it would not be due to any substance disorder or psychoactive substance disorder, and that if it were in context with an individual who had childhood autism that it was a specific noted diagnosis made only in the context where active

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hallucinations or delusions were manifested.

Q. What is autism?

A. Autism is a childhood illness that looks somewhat similar to schizophrenia. And then finally that the disorder was not found to be caused by another organic mental disorder, and that's schizophrenia.

Q. You said you were going to testify about the clinical course of the disorder. Before I ask that question, have you painted the picture that you wanted to paint?

A. Correct. I mean, that is schizophrenia.

Q. Now, let's go to your testimony about the clinical course of the disorder, would you paint us a picture of that?

A. Basically --

MR. SHEFFLER: Objection to the form of the question.

A. Basically a man begins from age 15 to 25 and women from probably 20, 25-ish to 35-ish, a little bit later onset in women, of course, generally is one of active episode with remittance of these episodes. Probably the majority of people do not have significant recoveries that are for their entire life duration, probably about a third of people have significant enough recovery to carry on a completely, totally normal life as

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we would generally consider it. About another third would need some assistance or help within the community, and then there would be, depending upon whose data you survey, between a third and maybe 40 percent that are going to need institutional care given to them for them to provide for their needs and that that course, for the most part, is lifelong and will probably, in most instances, require some care.

Q. (By Mr. Barrett) Are we through with the clinical course?

A. In a nutshell.

Q. You were going to testify about treatments for the disorder.

A. Uh-huh.

Q. Would you paint a picture or give it to me in a nutshell?

MR. SHEFFLER: Give him the nutshell version, Doctor?

A. You can base those primarily in two large categories, one, medication and then other therapies which largely would be verbal or supportive therapies or cognitive therapies or behavioral therapies, but for the most part, the main stay is medication therapy.

Q. (By Mr. Barrett) You really can't cure schizophrenia, can you?

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A. No. Psychiatrists can't.

Q. Did you see any other treatments that you hadn't described that Anderson Smith underwent?

MR. SHEFFLER: Objection.

Q. (By Mr. Barrett) From looking at the medical records?

MR. SHEFFLER: Objection. If your question is related to the -- Don, your question makes no sense. If you're asking what was Anderson Smith's treatment, then I --

Q. (By Mr. Barrett) Did you have any trouble understanding what I was asking?

MR. SHEFFLER: I think the record is unclear if you ask a question that's completely unrelated to your prior one and then say anything else, and that's exactly what you're doing here. That's an objectionable question.

Q. (By Mr. Barrett) Doctor, you want me to read the question back or can you answer it?

A. He received other somatic therapy which is still -- this is unfair. Let me back up. Medication is a form of somatic therapy.

Q. What is --

A. Somatic therapy means therapies that you do to somebody, that you --

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Q. Other than talking to them?

A. -- such as ECT, medicine, hypnotherapy, insulin coma therapy, et cetera. Today ECT in schizophrenia is very rare. In some states, it's illegal, but it's certainly rare, but in Anderson Smith's case, he certainly did receive ECT. He received other somatic therapy.

Q. That's electric troe shock therapy?

A. Correct, and he was institutionalized which was a treatment, and I would have to look at the records again to be certain that he didn't receive insulin coma treatment. He may have.

Q. Do you recall whether or not he --

A. I don't remember. It was a common treatment in his era.

Q. It's certainly not common any more, is it?

A. No.

Q. And tell us why it's not common.

MR. SHEFFLER: Objection.

A. There are better therapies.

Q. (By Mr. Barrett) Does it actually do harm occasionally?

MR. SHEFFLER: Objection.

A. It certainly could.

Q. (By Mr. Barrett) Does the literature that you're familiar with support the fact that electro shock

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therapy and insulin coma therapy both often cause permanent brain damage?

A. Insulin coma, the very concept of what you do, you induce a coma in a person by giving them a massive amount of insulin, lowers their blood sugar, go into coma, I think any lay person knows that would be dangerous. If you're not supplied with oxygen to the brain, if they do not bring you out of that coma quickly enough, surely you're going to sustain damage. I would say that ECT is a safe treatment to the brain. That's been a kind of come and go thing, but I think most people today would say that properly administered ECT with proper anesthesia was a safe treatment modality.

Q. You said that you would testify about the affect of the disorder on an individual's ability to function. Would you thumbnail or capsule or paint a picture?

MR. SHEFFLER: Give us the nutshell on that one, Doctor.

A. The level of function of someone who suffers from schizophrenia can go from A to Z, where they are totally completely dysfunctionate and would have to be taken care of as an infant to the point they could have manifest symptoms of the disease, such as some level of delusions, and yet function totally in an independent lifestyle. It would run the gamut, as far as diagnosis,

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from complete lack of function to essentially normal function.

Q. (By Mr. Barrett) Okay. So down there in number 8, where you said, "Individuals diagnosed with schizophrenia are capable of making voluntary and informed choices with respect to pleasurable, albeit risky activities," certainly you don't mean all individuals with schizophrenia, do you?

A. No.

Q. Because you said that runs the gamut from A to Z.

A. Sure.

Q. What pleasurable, albeit risky activities are you talking about?

A. Again, that kind of runs the gamut. Obviously this -- we specifically meant to include cigarette smoking but it could be other things.

MR. UPSHAW: You want him to name about a thousand more, Don.

MR. SHEFFLER: Please, nutshell version of that, too.

Q. (By Mr. Barrett) Number 9 says, "Dr. Hilsman will also discuss Mr. Smith's schizophrenia, the clinical source of Mr. Smith's disorder, and the symptoms and treatment of Mr. Smith's disorder." Let's go over them

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one by one. Do you believe that Anderson Smith had schizophrenia?

A. I have no reason to believe he didn't. I do believe he did.

MR. SCRUGGS: I'm sorry?

A. I have no reason to believe he did not have schizophrenia.

Q. (By Mr. Barrett) Was he suffering from any other mental disorder besides schizophrenia?

A. I don't know.

Q. During the delusional episodes of schizophrenia, would Anderson Smith have the ability to make an informed choice about smoking cigarettes, in your opinion?

MR. SHEFFLER: Objection, objection to any or all?

A. He very well should and could or could and should.

Q. (By Mr. Barrett) You said you will discuss Mr. Smith's schizophrenia. Give us a nutshell of that.

A. What I'll -- if called to do will be simply paraphrase the record when his illness begin, again, with the records that I have outlining the course in terms of time, of where those hospitalizations occurred, obviously the time when he was not in the hospital and the assumed plausity of records that don't appear to exist from the

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'60s, mid-'60s or whatever forward.

Q. I missed that. I'm deaf in my left ear.

A. The records I have pretty much leave off in the mid-'60s. I don't see much in the way of treatment or evidence of hospitalizations or flare-ups of illness in the latter '60s and into the '70s and obviously the '80s until he died.

Q. Do we in America institutionalize schizophrenics as much now as we used to?

MR. SHEFFLER: Objection.

Q. (By Mr. Barrett) As we did in the '50s?

MR. SHEFFLER: Objection. Is the question do we institution a number of people who's diagnosed with schizophrenia or a percentage of schizophrenics? That's the reason I had an objection to your question. If you understand what he's asking for, Doctor, please answer.

A. It is more difficult to obtain inpatient institutional psychiatric care in 1993 for the diagnosis of schizophrenia than it was in 1953.

Q. (By Mr. Barrett) Thank you. Let's go back to -- there was a Federal law that was passed that affected that -- the institutionalization of these people; was it not?

A. Correct.

Q. What was that act called?

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A. I don't remember the name of it.

Q. And --

A. I was actively involved with it, but I don't remember its name.

Q. How were you actively involved?

A. I'm a person who treated central Mississippi's discharged State Hospital population. They were mine. The street people were mine for any number of years, and for approximately 10 or more years, I was the State Hospital's out of house consultant, so they kind of -- when they were there, in a matter of speaking, they were vaguely under my vision, and then when they left, a large portion of those discharged, 3 or 4,000 ended up kind of semi under my care. A lot of them came to Jackson.

Q. And became street people?

A. Correct.

Q. When did this outpouring from the mental institutions of our country begin to take place? When did it first occur?

MR. SHEFFLER: Objection.

A. That I have knowledge of in the latter '70s.

Q. (By Mr. Barrett) And what has been the overall affect of that law as far as you're concerned?

MR. SHEFFLER: Objection.

Q. (By Mr. Barrett) From what you've observed

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from---

MR. SHEFFLER: Objection, overly broad.

MR. UPSHAW: What discoverable evidence --

Q. (By Mr. Barrett) As it relates to your own practice.

MR. SHEFFLER: How can he answer, relates to everything.

Q. (By Mr. Barrett) As it relates to his own practice?

MR. SHEFFLER: Patient load?

A. It really hadn't affected my practice at all, I mean, to what I do.

MR. SHEFFLER: You've answered the question.

Q. (By Mr. Barrett) You said that these people became your patients, that's what I was trying --

A. I'm sorry. In the late '70s, I was the director of the Hinds/Copiah/Jackson Mental Health Center, and they were -- you know, the majority of those people came under the direction and treatment of that mental health center, several thousands of them did, and part of my responsibility to go out into the community and treat them, but I quit doing that in about 1980 -- late '81.

Q. Are you saying that these thousands of people had formerly been institutionalized, and Federal law required that they be released?

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MR. SHEFFLER: Objection.

MR. UPSHAW: Don, let me say something. This is discovery. I don't disagree with that, but what admissible evidence is this reasonably calculated to lead to, seriously? We can be here a week. Does discovery just mean everything?

MR. SHEFFLER: Doctor, answer the question to the extent you can.

A. Say it one more time.

(Record read.)

A. Federal law mandated they be released, that's true.

Q. (By Mr. Barrett) What's the longest that you've ever followed a patient of yours with schizophrenia?

A. 10 or more years.

Q. 10 or how many more?

A. 11 and a half, I guess, somewhere in that neighborhood.

(Off the record.)

Q. The symptoms that you were going to discuss, the symptoms and treatment of Mr. Smith's disorder.

A. Uh-huh.

Q. Nutshell that for us.

MR. SHEFFLER: To the extent you already haven't. You've asked this question twice now.

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MR. BARRETT: Why did you put it in his document that you prepared or Tom Riley or whoever did it if you didn't want to talk about it? I mean, you put it in here, and I'm asking about it.

MR. SHEFFLER: I'm not having a problem that you ask, but you've already asked the question twice. This is now the third time you've asked this question about his treatment.

MR. BARRETT: When you read the record, you will see that you are mistaken. This is the first time we have asked about the symptoms and treatments of Mr. Smith's disorder.

MR. SHEFFLER: You've asked about the treatment of Mr. Smith's disorder, you've asked him to compare it to what he said the treatment for schizophrenics were, you've talked about insulin coma shock ad nauseam, and now you're asking him to do it all over again. I object. Asked and answered.

Q. (By Mr. Barrett) Dr. Hilsman, go ahead, please.

A. I will simply, if asked, paraphrase this man's treatment and his diagnoses, including his hospitalizations that I have privy to that would have begun in the late '40s and ultimately, to the best of my knowledge, culminated in his last admission in the '60s.

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Q. You say number 10, "The diagnosis of schizophrenia did not prevent Mr. Smith from making voluntary choices." What do you mean by that?

A. I mean that the word "schizophrenia" or his suffering from that disorder did not prevent him from having the capacity of making choices which were voluntary, free will. He had the capacity to appreciate and understand.

Q. To appreciate and understand what?

A. The choices and their assumed outcome.

Q. Because schizophrenia, itself, does not prevent that; is that what you're saying?

A. Correct, uh-huh.

Q. And you're saying, as I understand it, that the diagnosis of schizophrenia would not prevent anybody from making voluntary choices?

A. In a global sense, correct.

Q. In other words, you're not looking at any particular part of Mr. Smith's medical record and saying this is why I say this applies to Mr. Smith, is that --

MR. SHEFFLER: Objection.

Q. (By Mr. Barrett) Is that correct or not?

MR. SHEFFLER: Objection, to the extent he's basing his opinion on the records.

A. Surely this is -- we're talking about

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Mr. Smith. I include him as a schizophrenic, I include him as a person having schizophrenia, and on review of those records, I can detect no reason to believe, either because of his schizophrenia or anything else I could reveal that he would not have the ability to make voluntary choices.

Q. Look at number 11, you said, "At various times during Mr. Smith's life, Mr. Smith exhibited the ability to quit smoking and to successfully act upon such a decision." All right. Which times?

A. The times when he was not -- and I use this -- we could delineate them specifically, but for the sake of whatever, blatently and flagrantly psychotic. There are episodes in there where he is described as being disoriented and grossly confused and obvious -- I mean, a lay person could see the man is sick, and it is -- it is probable, that given that degree of emotional psychiatric embarrassment, that his ability to attend to the question of smoking, its antecedental risk and decision to stop would be seriously compromised. I'd certainly give anybody that, but there also, you know, and really in the larger periods of time when he's not blatently psychotic where he's not disoriented, not confused, may, on occasion, be a little delusional, may, on occasion, be under the care or the aegis of a guardian, but certainly

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not representing anything that I could detect that would free him from the ability to make an informed consent.

Q. Would you agree that judgment -- you've already said that judgment is one of the things -- one of the factors that act on this decision.

MR. SHEFFLER: He's already said it. He's not going to say it again. Asked and answered.

Q. (By Mr. Barrett) Do you agree?

A. Yeah. Yes.

Q. And you certainly will agree that -- do you believe that Anderson Smith's judgment was impaired when he was not in the hospital?

MR. SHEFFLER: Objection. The question has been asked and answered repeatedly.

A. I do not specifically know the answer to that. I don't have data that would support that it was seriously impaired at all times or even -- even large times.

Q. (By Mr. Barrett) What sort of data were you talking about would be the kind you'd look at?

A. Well, you know, any evidence that would support the man couldn't use common sense, decent common sense judgment. I mean, you know, if he was sitting inside of a house that was burning down, I mean, you'd say his judgment was pretty poor if he didn't get up and leave.

Q. In what way or ways did Anderson Smith, using

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your words, exhibit the ability to quit smoking?

MR. SHEFFLER: Objection. As I said before and stipulated by me, that report was prepared by my office and was submitted to you as an answer to interrogatories as you well know.

A. Ask me one more time, please.

(Record read.)

A. I think the ability to quit smoking is an innate human ability. I mean, I think a person who -- it speaks for itself. If you want to quit, you quit. Nothing to indicate that he didn't have that natural innate human ability like me or you or anybody else, and not having any data to support that he didn't have that which is human and within us all, I postulate that he had it as I have it.

(Off the record.)

Q. Let me just -- I know that Mr. Sheffler needs to catch an airplane, but let me just go back over a couple of questions here.

MR. SHEFFLER: Take your time.

Q. (By Mr. Barrett) Do you consider yourself an expert in the field of marketing or advertising, Dr. Hilsman?

A. No.

Q. You've not had any training or education in

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those fields, have you?

A. No.

Q. You said that -- you talk about or speak of in paragraph 12 there about the -- I say you do, Mr. Sheffler does, we all know that. I've known that for years, Doctor, the alleged vulnerability of individuals diagnosed with emphysema with external influences, including advertising. Do you have any idea what Mr. Sheffler means by that?

A. I don't know what he means. I know what I mean.

Q. What do you mean?

A. I mean that one of the assumptions that was at least discussed with me was whether or not this person would be more vulnerable to influence, now, if you could persuade him or dupe him or present him to act in one way that perhaps he wouldn't act in another, et cetera, and of course, having read Dr. Macvaugh's interrogatories or whatever, it's quite clear the direction that those interrogatories lead one to believe that this could go.

My statement to that is basically that to assume that a person who carries a diagnosis of schizophrenia is more vulnerable to external influence is simply foolish and that one could make a better argument that a person who was a paranoid, distrustful, doubtful of motives of others would be even less possibly led to make decisions

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than someone who didn't suffer the disorder.

Certainly someone who would be described as incoherent and socially isolated and withdrawn is probably going to be far less privy to the influence -- external influence than you or I would be. That statement does not say or it is not meant to say that people with schizophrenia might have periods of time where they might be more vulnerable, but to make some assumption that the diagnosis itself implies vulnerability, it would probably be easier or more wise to make the assumption that it actually does not.

Q. Dr. Hilsman, are you saying that a schizophrenic is, in some way, less capable of receiving the message of any particular advertisement -- of an advertisement?

MR. SHEFFLER: Objection.

A. They may actually be. They may actually cognitively receive such information less so than we.

Q. (By Mr. Barrett) Do you believe that's true for Mr. Smith?

MR. SHEFFLER: Objection.

A. I don't see anything in his chart that would make me believe that he would be at serious prey to external influence in any kind of global or longstanding fashion.

Q. (By Mr. Barrett) But that's not -- that wasn't

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my question. Let me -- and I take the blame. Did you see anything in his records which would tend to indicate that he would be less capable of receiving a message from an ad than --

MR. SHEFFLER: Object to the form of the question insofar as the capable of receiving a message from the ad has not been defined. Dr. Hilsman was talking about the effective advertising. Now, you've changed the question without defining it.

Q. (By Mr. Barrett) Go ahead, Doctor.

A. I think anyone actively psychotic would, in all likelihood, have a decrement in receiving information such as an advertisement. Now, granted, if their particular delusion may encompass that which the ad may entitle itself to, sure it would be different, but in a kind of general sense, actively psychotic people will be dealing with their psychosis and not with the external world.

Q. Yes, sir, but what about all those other times when he was not with an active psychosis, the years when he was living at home in Kosciusko, is it your testimony that he was less capable of receiving a message from an advertisement than a normal person?

A. He may have been.

Q. Well, is it your opinion that he was?

A. It's my opinion that he may have been, and

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that's fair.

Q. Well, that's no answer at all.

A. Well, it is.

Q. Anything -- I mean, is it possible or is it probable?

A. It's -- with the medical records that I have before me, it's a may. With the likelihood of receiving a kind of ongoing documents of the way this man behaved, acted from perhaps other depositions of people who knew him in kind of a lay sense, I could probably come a lot closer to giving you a yes, no, medical probability answer.

At this point, I'm uncomfortable with doing that and would say that it is clearly a good possibility that he might have been less capable of receiving that type information and processing it.

Q. Would you say it's probable?

A. I can't say that.

Q. Doctor, are you not prepared here to give your testimony at trial?

MR. SHEFFLER: Objection.

A. I would -- if asked questions such as that, I would answer them in trial just like I just answered.

Q. (By Mr. Barrett) You said something about that you're going to -- you intend to get further information.

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MR. SHEFFLER: Objection. He did not say that. That's misstating the record once again.

Q. (By Mr. Barrett) Whatever you said led me to believe that. What are you talking about?

MR. SHEFFLER: Ask him a question about --

Q. (By Mr. Barrett) What are you talking about, Doctor?

MR. SHEFFLER: Object to the question.

Q. (By Mr. Barrett) Go ahead, Doctor. Don't pay any attention to him. We'll never get out of here.

A. If data could be provided me that would give a better sketch in those medical records for those gap periods, I would have far better ability to generate opinion from probable to maybe or whatever. Without that data, I would have to say that the best I could do is what I told you and to say that it may is the best answer I can give you.

Q. Is it your testimony that schizophrenics generally are less capable of receiving a message from an ad than a normal person?

MR. SHEFFLER: Objection.

A. They may be. What I'm saying is that paranoid schizophrenic may be less susceptible at receiving material and advertisement than others based on their basic distrust and -- that may even continue when they're

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no longer actively psychotic.

Q. (By Mr. Barrett) Do you think that's probably so or not probably so?

MR. SHEFFLER: Objection.

A. In his case, I'm going to have to hold with may.

Q. (By Mr. Barrett) I'm not talking about his case. Talking about schizophrenia generally.

MR. SHEFFLER: Paranoid schizophrenia?

A. In paranoid schizophrenia?

Q. (By Mr. Barrett) Yeah.

A. I think it is probable to say that their basic mistrust and distrust of others would make them more suspect of such things that would fall under the general banner of advertisement campaigns as I understand that word to mean.

Q. It's your opinion that his diagnosis was paranoid schizophrenia, that Smith's diagnosis was that?

A. That's what's in the records.

(Off the record.)

Q. Schizophrenics, paranoid schizophrenics have a tendency to not receive advertising messages as well as normal people. Have you testified to that, is that your opinion?

A. I said that they may receive advertising campaigns less efficiently than their non-schizophrenic

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cohorts.

Q. By the same token, then, they may receive other information in the same way; is that correct?

MR. SHEFFLER: Objection.

A. That -- when you say "other information", it would probably be easier for me to answer that if you would define "other".

Q. (By Mr. Barrett) Okay. Let's say for example the warning label on a cigarette pack, how about that?

A. Okay.

Q. Will you grant that they would be less likely to believe that, may be less likely to believe that just as they would be less likely to believe an ad?

A. I suppose that is a possibility. Where I could make an argument that that would not be surely as good a possibility is the fact that the ad -- granted, now, they could be actively psychotic or feel that the Federal government was trying to trick them, you know, excluding all that.

Q. Excluding all that.

A. The assumption, I think, that even the most paranoid individual would make on a warning would be, if anything, they would probably overreact to a warning. They're already distrustful and fearful of the motives of others, one of these people that they may be distrustful

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of, which in his case you just keep extrapolating, largely with white people, and extrapolating what he might see as to these warnings, he might even be more predisposed to be afraid of them. Paranoid people are generally afraid of the motives of other people and also probably more predisposed, in some sense of the word, to a warning, simply because they're paranoid.

Q. They don't believe what people are telling them?

A. They may not.

(Off the record.)

Q. Do you think that advertising influences people to buy product advertised?

MR. SHEFFLER: Objection.

A. I think so.

Q. (By Mr. Barrett) Do you think that advertising is often designed to send certain messages to consumers?

MR. SHEFFLER: Objection to the breadth of the question. All advertising, some advertising, a little bit, any?

A. I would assume that probably that's part of its capacity.

Q. (By Mr. Barrett) Do you believe that the American Tobacco Company has ever suggested,, through advertising that cigarettes did not pose a threat to human health?

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MR. SHEFFLER: Objection.

A. Say that again.

Q. (By Mr. Barrett) Do you believe that the cigarette industry has ever -- that the American Tobacco Company, excuse me, has ever suggested through advertising that cigarettes did not pose a threat to human health?

MR. BAILEY: Are you asking his personal opinion? You've already established early on that he's not an expert in marketing and advertising, so how in the world could that be a germane question to a deposition of him as an expert witness.

MR. REILLY: He's also said he hasn't reviewed any advertising or marketing tools.

MR. BARRETT: One, two, three, four.

MR. SHEFFLER: All right. I object to the question, Don.

A. And I don't know the answer. I don't know. I really don't.

MR. SHEFFLER: That's an answer.

Q. (By Mr. Barrett) Do you believe that the cigarette industry has ever suggested -- and I'm limiting this question up until January 1, 1966 -- has ever suggested through advertising that cigarettes did not pose a threat to human health?

MR. SHEFFLER: Objection.

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A. I don't know.

Q. (By Mr. Barrett) do you believe that cigarette advertising has been somewhat successful in promoting the sale of cigarettes to Americans?

MR. SHEFFLER: Objection. I don't know what you mean by "somewhat successful", but I object as to the breadth of the question. Number one, there's no time frame, number two, you don't define what you mean by successful, number three, it has no relevance to his opinions in this case.

A. I don't know.

Q. (By Mr. Barrett) You said -- look at number 13 there -- that you'll testify by Mr. Smith's personality. Give us a thumbnail sketch of that.

MR. SHEFFLER: To the extent you haven't already testified.

Q. (By Mr. Barrett) To the extent you haven't already testified.

A. I don't know of anything I would say that I hadn't already paraphrased, and that would be as well inclusive of the remainder of your underlying portion of that.

Q. Well, take 30 seconds and tell me about Mr. Smith's personality.

MR. SHEFFLER: Objection. Don, you've already

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asked that question, and he already did.

MR. BARRETT: I don't think he did.

MR. SHEFFLER: You did in connection with --

MR. BARRETT: You're just slowing us down now.

MR. SHEFFLER: Let me just tell you, you already asked this question with respect to the decision to smoke when you asked about Anderson Smith's personality. If the Doctor has anything to add to that answer, let him do so; otherwise, we're going to be here forever if you're going to revisit every one of these questions..

MR. BARRETT: I'm going to finish this like I'm going to finish it, and you're slowing us down. Just give us a brief --

MR. SHEFFLER: Anything to add, add it.

Q. (By Mr. Barrett) Let's start over, Doctor, and I'm going to ask the question. Give us a thumbnail sketch of Mr. Smith's personality.

MR. SHEFFLER: Objection, asked and answered.

Q. (By Mr. Barrett) Don't refer to anything else you've already said, just give it to us here.

MR. SHEFFLER: To the extent you have anything to add, Doctor, add it.

A. Only thing actually that I meant by that statement that would not have already been stated was that there was some evidence in his social history to indicate

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that he may have had some of the personality traits of an individual who ultimately developed schizophrenia.

Q. (By Mr. Barrett) Explain that a little bit. Be specific.

A. Oh, they make statements that he was a good child, dependent, in gist you get he's kind of an obedient kid, he stayed around home, and we know -- there's certainly a lot of kids that way that don't turn out to be schizophrenics. We know retrospectively that a lot of children that become schizophrenics are described by their parents as perfect little boys and not unruly and such as that.

Q. Mama's boys?

A. Can be, uh-huh.

Q. Remember him being described that way?

A. Uh-huh.

Q. "Dr. Hilsman will also testify about Mr. Smith's appreciation of health risks generally." What does that mean?

A. It's my opinion that he would have had an equal ability to appreciate health risks of any one of his community.

Q. And what do you base that on?

A. No reason to assume otherwise.

Q. From the medical records, there's not anything

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in there that would show you?

A. Outside of the scope of his being grossly psychotic, he would have the ability to appreciate usual and customary health risks.

Q. What documents do you rely on here for -- any specific documents in the records that you can --

MR. SHEFFLER: Objection. To the extent you recall any specific, Doctor.

A. Not any that I can think of specifically, sir.

Q. (By Mr. Barrett) What about specific events in his life?

MR. SHEFFLER: Same objection.

A. One might make the argument that he perceived that alcohol was a health risk, and it's alleged that he discontinued alcohol consumption late in life which would to me be pretty apropos of the fact that he took a volitional approach to something that probably required a certain amount of motivation and effort and appears to have been successful according to the medical records.

Q. (By Mr. Barrett) What year did that occur, do you remember?

A. It's in the medical records from the last admission, '86.

Q. Number 14, "Dr. Hilsman bases his opinion on, among other things, your review of his medical records and

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other information about Mr. Smith." I think we've been over this. Are there any specific medical records that you consider particularly relevant?

MR. SHEFFLER: Objection.

Q. (By Mr. Barrett) Other than the ones you've already told us about?

MR. SHEFFLER: Objection.

A. No.

Q. (By Mr. Barrett) What other information -- you base your opinion on other information about Mr. Smith. What other information do you have?

A. Other -- I don't.

Q. So that's wrong, isn't it?

A. It would appear.

Q. Well, it is wrong, isn't it? Sir?

A. I don't have any other information about any --

Q. So just say yes.

A. Yes.

Q. It said in his review of pertinent scientific medical literature. What specific scientific and medical literature do you consider pertinent?

MR. SHEFFLER: Objection, unless you have any specific literature in mind that you can cite, Mr. Barrett. He is not by his question going to limit you to all your review of all your medical textbooks and anything

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else that you have during your entire professional career.

A. The truth of it is, what I meant by that is when you get to a point of being a board certified psychiatrist obviously you have digested a large amount of material, you may not rely on any one specific source.

Q. (By Mr. Barrett) That's just my point. I want to know are you going to rely on any one specific source?

MR. SHEFFLER: He's asking for anything in addition, Doctor.

Q. (By Mr. Barrett) I don't want you to come up at trial and say, "I've got the article right here, Mr. Barrett," pi-tou.

A. And I assure you if I were to do that, I'd do everything in my power to give it to you before it happened.

Q. Let me tell you for the record that my address is [DELETED] and I would an appreciate it if you did that.

MR. SHEFFLER: He'll give it to us, and we'll give it to you.

A. Right.

MR. SHEFFLER: By Federal Express.

Q. (By Mr. Barrett) Dr. Hilsman, have you ever testified before?

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A. Yeah.

Q. On how many different occasions have you testified?

A. Before an open court -- the reason I'm paraphrasing that, I used to do lunacy hearings, and that is technically testifying, and I did that in the capacity under the Mental Health Center banner, and I did hundreds of lunacy hearings.

Q. Well, let's talk about that before we go to anything else. What would you do at a lunacy hearings? You would examine somebody to see if they were --

A. Whether they were basically, for lack of a better way of putting it, committable, whether or not they demonstrated the requirements to meet, at that time, Mississippi's commitment law.

Q. Whether they were lunatics or not? Sir?

A. That is a legal definition, that's true.

Q. And how many people have you committed over the years?

A. Oh, gee.

MR. UPSHAW: Object to the form.

Q. (By Mr. Barrett) How many people have you testified that needed commitment, do you suppose?

A. Probably 50 to a hundred, maybe more.

Q. Have you ever testified in favor of the stiff

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that's trying to go home?

A. I've gone both ways.

Q. How many times have you gone the way of the alleged lunatic?

A. Well, of course, we had -- I kind of ran the show, we could, at times, beg the court to do an outpatient treatment, so that would -- most -- in fairness, to get -- in that era to be jailed and brought before the court to go to Whitfield, there were very few people who were say divorcees dragged down there to get something done under the table, most those people really were ill and needed some help somehow. They were all certainly not legally insane, but they -- they were hurt.

Q. What county was that in?

A. That was in Hinds.

Q. What period of time?

A. That would have been '77 to maybe '82, somewhere in there, about three or four years.

Q. Other than your lunacy hearings, have you ever testified?

A. Uh-huh, I believe I've testified in every court environment in this state other than Supreme Court. Chancery Court, Circuit Court.

Q. How many times have you testified?

A. Probably 15-ish maybe. That's close, I would

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guess. It's been years since I've been in court, but it would be about, I'd guess 15.

Q. When is the last time you were in court?

A. I think it was about five years ago, and it was a divorce hearing, I think that's the last time I've been in a court room.

Q. Who were the lawyers involved?

MR. UPSHAW: We weren't, Don, if that's important.

A. Actually, it was Bill Waller and -- oh, God, hold on.

MR. UPSHAW: Do you really care?

MR. BARRETT: Yeah, I really do care.

A. God.

MR. SHEFFLER: Leave a blank in the record, Doctor, and if you remember when you review the transcript, put the name in it.

A. I can't recall.

Q. (By Mr. Barrett) Have you ever testified about schizophrenia before?

A. I've testified about schizophrenia in reference to competency to stand trial and criminality of their behavior.

Q. In what cases?

A. It would have been in the '70s, and I did it

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both ways. You know, I did with -- it in times when I was -- the person was criminally insane, I've done it --

Q. I didn't hear what you said.

A. I had done it when I believed that a person was, in fact, criminally insane, the defense, and I've also, in years past, particularly when I was with the Mental Health Center, did it with the Hinds County district attorney's office in the reverse of that.

Q. Can you give me the names of some of the people you testified --

A. Oh, no, the people, no.

Q. The subjects, the accused persons.

A. No, I wouldn't have any idea. I mean, this has been late '70s. I could -- I don't know. In fact, I guess because it's a public record I could say there's no confidentiality. The one person I remember that sticks out was the Crawford Bullock thing, and the intriguing thing about that is it ultimately -- of course, they were paired. One was ultimately given the death sentence, and the other was not, and it became kind of a Supreme Court issue and issue of a lot of people's understanding. That's the last one that I recall.

Q. And the defendant -- the person you examined was named Crawford Bullock?

A. Yes. That's the best I recall. It's either he

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or his accomplice, and I can't remember. I think I saw both of them. It's been so long.

Q. What was the accomplice's name?

A. It's been 15 years, but my testimony was given -- or the testimony I gave was that I held the criminality of the person --

MR. SHEFFLER: Doctor, he asked you who.

A. I misunderstood you. I don't remember the person's name.

Q. (By Mr. Barrett) Have you ever testified that because of a particular person's schizophrenia he was unable to tell right from wrong?

A. Yes.

Q. How many times?

MR. SHEFFLER: Objection, asked and answered.

A. I don't remember. It wouldn't be more than once or twice. It's been years past. Again, I don't remember who.

Q. (By Mr. Barrett) Do you remember what court it was in?

A. It would have been the Circuit Court of Hinds County and one other -- I don't even remember what county I was in. It's the last time I had any involvement with State Hospital in a court case, and actually the State Hospital testified in this man's behalf that he was, in

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fact, criminally insane. That would have been 10 years ago.

Q. What was the lawyer's name?

A. Don't remember, honestly don't.

Q. Would you have any record of that at your office?

A. I'm sure it's there, but not knowing the person's name, I wouldn't know how to retrieve it. Again if I remembered it, I wouldn't mind in the least bit letting you know that information.

MR. SHEFFLER: Doctor, would you give us that information and we'll pass it along?

A. Certainly.

Q. (By Mr. Barrett) Doctor, I see that you -- in April of 1985 you successfully completed part one of your boards.

A. Uh-huh.

Q. Did you fail anything that time?

A. Huh-huh.

Q. All you took was part one?

A. Well, if you drop down the next --

Q. I see that.

A. There's only -- the boards are made up of a written exam which is part one, and that's made up of a psychiatry section and neurology section, and you can

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technically pass psychiatry, fail neurology or vice versa; obviously, I didn't fail either one of them.

Q. Did you pass both of them the first time you took them?

A. Uh-huh.

Q. And I assume you did just as well on your orals?

A. Uh-huh.

MR. BARRETT: That's it.

MR. AKERS: No questions.

MR. BAILEY: No questions.

MR. BARRETT: Let's at this time introduce the response that Dr. Hilsman has been talking about and using today that are numbered on the right and in the right margin and yellow highlighted by me in which he said is the same as Deposition Exhibit Number 2, let it be marked as deposition Exhibit Number 4.

(Exhibit 4 marked for identification.)

(Time Noted: 5:35 p.m.)

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CERTIFICATE OF DEPONENT

I, Dr. Gray Hilsman, deponent in the deposition taken in the herein styled and numbered cause, certify that I have examined the foregoing pages, 143, being the total number of pages relating to my testimony, as to the correctness thereof, and that after reading said pages, I find them to contain a full and true transcript of the testimony as given by me on February 4, 1993, in Jackson, Mississippi.

Subject to those corrections listed below, if any, I find the transcript to be the correct testimony I gave at the aforestated time and place.

Page	Line	Comments
9	20	now → row
10	6	vita
27	7	it → he
28	11	country → historian
40	19	ed → d first

This the _____ day of _____, 1993.

GRAY HILSMAN, M.D.

State of Mississippi
County of Hinds

Subscribed and sworn to before me, this the 9th day of March, 1993.

My Commission Expires:

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Notary: Caroline Kay Boyd
3-9-93

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Page	Line	Comments
43	17	Smith Bern
61	11	place that pair of individuals afterward
70	3	attenuate → attendant
73	17	ae → is
83	19	attenuate → intend
86	23	and → of
95	19	place to pair is that
107	2+3	period following that
107	6	"schizophrenia"
115	25	Hensity → density
117	2	Depue V.A.H.
122	9	[illegible] → [illegible]
129	23	deny - at to to

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Page	Line	Comments
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This the _____ day of _____, 1993.

_____

GRAY HILSMAN, M.D.

State of Mississippi
County of _____

Subscribed and sworn to before me, this the _____ day of _____, 1993.

My Commission Expires:
_____

_____
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CERTIFICATE OF COURT REPORTER

I, Ginger H. Brooks Court Reporter and Notary Public in and for the County of Hinds, State of Mississippi, hereby certify that the foregoing pages, 143 and including this page, contain a true and correct transcript of the testimony of Dr. Gray Hilsman, as taken by me in the aforementioned matter at the time and place heretofore stated, as taken by stenotype and later reduced to typewritten form under my supervision by means of computer-aided transcription.

I further certify that under the authority vested in me by the State of Mississippi that the witness was placed under oath by me to truthfully answer all questions in this matter.

I further certify that I am not in the employ of or related to any counsel or party in this matter and have no interest, monetary or otherwise, in the final outcome of this proceeding.

Witness my signature and seal this the 5th day of February, 1993.

GINGER H. BROOKS

RPR, CSR- MS,OK,TX

My Commission Expires:

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